PUBLIC RECORD

Dates: 08/01/2025 - 17/01/2025; 03/06/2025 - 04/06/2025

Doctor:	Dr Cian HUGHES
GMC reference number:	7280579
Primary medical qualification:	MB ChB 2012 University of Bristol

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 12 months
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Duncan Ritchie
Lay Tribunal Member:	Ms Wanda Rossiter
Registrant Tribunal Member:	Dr Suzanne Joels

Tribunal Clerk:	Mx Nate Caruso-Kelly (08/01/25 – 17/01/25) Ms Hinna Safdar (03/06/25 – 04/06/25)

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Ms Rebecca Harris, Counsel, instructed by Weightmans
GMC Representative:	Ms Colette Renton, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 15/01/2025

1. This determination will be handed down in private. However, as this case concerns Dr Hughes' misconduct a redacted version will be published at the close of the hearing.

Background

2. Dr Hughes qualified in 2012 at the University of Bristol. At the time that Dr Hughes met Patient A in 2011, Dr Hughes was a fourth-year student at the University of Bristol. Following qualification, Dr Hughes completed his Foundation Years training and worked in a number of hospitals in London as a middle grade doctor between 2015 and 2022. Dr Hughes also undertook work for Google DeepMind Health from 2015 and continues to work for Google in Ireland.

3. The allegation that has led to Dr Hughes' hearing is as follows. On or around 10 March 2011 Dr Hughes observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, Dr Hughes sent messages to Patient A between 2011 and November 2013 which were inappropriate in that: he used his professional position to pursue an improper emotional relationship with Patient A, the messages were not part of Patient A's medical care, he sent the messages directly to Patient A and no one else, and he was aware that Patient A had developed personal feelings for him from April 2013.

4. It is further alleged that from December 2013 Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A in that he sent messages to her which were inappropriate in that: he was aware that Patient A had

developed personal feelings for him from April 2013 or December 2013, the messages were not part of Patient A's medical care, he sent the messages directly to Patient A and no one else and the nature of the messages became personal and more frequent.

5. It is alleged that the messages Dr Hughes sent to Patient A from 12 October 2014 were with the intention of pursuing a sexual relationship with Patient A and were sexually motivated. Further that Dr Hughes entered into a sexual relationship with Patient A in that, on one or more occasions from October 2014 he kissed Patient A, from February 2015 engaged in sexual activity with Patient A, and from 29 May 2015 he engaged in sexual intercourse with Patient A. It is finally alleged that Dr Hughes knew that Patient A was vulnerable at all material times by virtue of her age prior to turning 18, and her mental state, XXX.

6. Patient A made a complaint to the Police in June 2020 and was interviewed in relation to the matter on 4 January 2021. The initial concerns were raised with the GMC shortly thereafter. The police investigation was discontinued with no charges against Dr Hughes.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted the GMC's preliminary application, made pursuant to Rule 17 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') to amend the Allegation. The Tribunal's full decision on the application is included at Annex A.

The Allegation and the Doctor's Response

8. The Allegation made against Dr Hughes is as follows:

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

1. On or around 10 March 2011 you observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, you sent messages to Patient A between 2011 and November 2013 as set out in Schedule 1, which were inappropriate in that:

    a. you used your professional position to pursue an improper emotional relationship with Patient A;

To be determined.

b. the messages were not part of Patient A's medical care;

Admitted and found proved.

c. you sent the messages directly to Patient A and to no one else;

Admitted and found proved.

d. you were aware that Patient A had developed personal feelings for you from April 2013.

To be determined.

2. From December 2013 you used your professional position to pursue an improper emotional relationship with Patient A in that you sent messages to her, as set out in Schedule 1, which were inappropriate in that:

a. you were aware that Patient A had developed personal feelings for you from either:

i. April 2013; or

To be determined.

ii. December 2013;

Admitted and found proved.

b. the messages were not part of Patient A's medical care;

Admitted and found proved.

c. you sent the messages directly to Patient A and to no one else;

Admitted and found proved.

d. the nature of your messages became personal;

Admitted and found proved.

e. your messages became more frequent.

Admitted and found proved.

3. You sent Patient A messages from 23 October 2014 to 2015 as set out in Schedule 1 with the intention of pursuing a sexual relationship with Patient A.

Admitted and found proved.

4. You entered into a sexual relationship with Patient A in that you, on one or more occasions, from:

a. October 2014 kissed Patient A;

Admitted and found proved.

b. February 2015 engaged in sexual activity with Patient A;

Admitted and found proved.

c. 29 May 2015 engaged in sexual intercourse with Patient A.

Admitted and found proved.

5. Your actions at paragraph 3 were sexually motivated.

Admitted and found proved.

6. You knew that Patient A was vulnerable at all material times for the reasons set out in Schedule 2 below.

Admitted and found proved.

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.
To be determined.

The Admitted Facts

9. At the outset of these proceedings, through his counsel, Ms Harris, Dr Hughes made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the

Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

10. In light of Dr Hughes' response to the Allegation made against him the Tribunal is required to determine whether Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A between 2011 and November 2013. Further, the Tribunal is required to determine whether Dr Hughes was aware from April 2013 that Patient A had developed personal feelings for him.

Witness Evidence

11. The Tribunal received evidence on behalf of the GMC in the form of a witness statement from Patient A dated 14 December 2022. Patient A was not called to give oral evidence.

12. Dr Hughes provided his own witness statement dated 17 December 2024 and also gave oral evidence at the hearing.

Documentary Evidence

13. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- iMessages and emails between Patient A and Dr Hughes, dated between 2011 and 2018;
- Emails between Patient A and her grandparents dated between December 2014 and June 2015;
- Emails between Patient A, Dr Hughes and her mother dated between February 2015 and November 2015;
- An email to Patient A's brother dated 25 January 2015;
- An email between Patient A and XXX dated 12 November 2015;
- Dr Hughes' prepared statement for the police dated April 2020; and
- Emails between Dr Hughes and his roommate dated August and September 2014.

The Tribunal's Approach

14. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Hughes does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e., whether it is more likely than not that the events occurred.

15. The Tribunal is advised to:

- Avoid the fallacy of the confident witness – a confident witness may still be mistaken or misremember important details. An honest but mistaken witness can construct an entirely false memory.

- Remember that demeanour is not a reliable pointer to the honesty of a witness' account and the Tribunal should not rely exclusively on a witness's demeanour when giving evidence.

16. The Tribunal must consider all of the evidence before it before making findings as to the credibility of any witness. Any assessment of credibility must be based on inferences drawn from the documentary evidence and any known or probable facts.

17. The Tribunal may draw reasonable inferences from the facts, using common sense and from experience. The Tribunal may also attach what weight it considers appropriate to the evidence it has received. However, it would be wrong for the Tribunal to enter into speculation about matters or for example to consider what evidence might or might not have been available in the case. The Tribunal must decide the case purely on the evidence that has been put before it and must not speculate about what other evidence there may have been.

18. The Tribunal has heard that Dr Hughes had not, at the time of the outstanding allegations, previously behaved in the manner alleged by the GMC in these allegations. His good character must be taken into account by the Tribunal when assessing his credibility and the likelihood of his having done what has been alleged. Good character is not a defence to the allegations, however: it is simply one factor to take into account when considering all of the evidence in the round. The weight to assign to his good character is a matter for the Tribunal to determine.

The Tribunal's Analysis of the Evidence and Findings

19. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Further Background

20. The Tribunal was assisted in its considerations by the following further background, the facts of which are either admitted by Dr Hughes or agreed between the parties.

21. Patient A had a XXX surgery at Bristol Royal Hospital for Children on 10 March 2011 under the care of Consultant Orthopaedic Surgeon Mr B. The surgery was intended to relieve the symptoms XXX. At the time, Dr Hughes was a fourth-year medical student at Bristol University, and he was invited by Mr B to observe and assist with Patient A's surgery. Dr Hughes visited Patient A on the ward on 15 March 2011 XXX. As part of this conversation, Patient A asked for copies of her x-rays and Dr Hughes forwarded them to her from his personal email as he was unable to access his NHS email. Because Dr Hughes sent the x-rays from his personal email, Patient A came to know his personal email address and subsequently used this to send emails to Dr Hughes. The signature at the foot of the emails which Dr Hughes sent to Patient A at this stage also contained both of his mobile phone numbers.

22. Throughout Patient A's stay in hospital, Dr Hughes returned to speak to Patient A. Dr Hughes observed Patient A's surgery and assisted in closing the incision. Patient A was discharged after six weeks. At this time Patient A was aged 13 and about to begin her GCSEs.

23. Patient A and Dr Hughes continued to email each other between April 2011 and December 2013, discussing school, University choices, and Patient A's ongoing treatment. Patient A sent Dr Hughes for his comment more than 50 poems which she had written. Dr Hughes responded to Patient A, sharing his comments about the poems which Patient A had written.

24. In December 2013, Patient A and Dr Hughes begin to exchange iMessages. Patient A had received an iPod touch for Christmas, and this facilitated the contact. At this time Patient A was aged 16 and had moved schools to attend sixth form. They exchanged multiple messages daily, discussing more personal topics XXX.

25. On 11 October 2014 Patient A arranged to meet Dr Hughes while she was visiting XXX. At this time Patient A was aged 17 and in year 13. Dr Hughes had completed his medical training and was working XXX as a surgical trainee. This was the first time Patient A and Dr

Hughes had seen each other since February 2012 when she was having a procedure the hospital.

26. On 23 October Dr Hughes messaged Patient A and asked if she would be interested in a romantic relationship with him. Patient A accepted and they arranged to meet XXX.

27. On 27 October 2014 Patient A arranged to meet Dr Hughes XXX again. Dr Hughes kissed Patient A. The relationship continued with extensive messaging on a daily basis and of an increasingly personal and sexual nature.

28. Between 27 and 28 December 2014 Dr Hughes was invited to stay at Patient A's family home by her parents. Dr Hughes and Patient A kissed, which Patient A's parents were unhappy about. They exchanged Christmas presents, including green socks which had become an 'in joke' between the two.

29. Patient A visited Dr Hughes on 1 January 2015 for the day. They spent the day at XXX and then engaged in kissing and some limited sexual activity at Dr Hughes' flat before Patient A travelled home.

30. Dr Hughes was invited to stay at the family home again on 24 January 2015 and Patient A once again went into his room. Patient A stated that after Dr Hughes left she was told off by her parents.

31. Patient A went to stay with Dr Hughes at his flat XXX on a further six occasions - 25 January, 6 and 7 February, 18 and 19 February, 6 to 7 March, 9 to 12 April and 1 to 3 May 2015. On each occasion sexual activity occurred, but not sexual intercourse. Patient A and Dr Hughes messaged extensively about whether or not she wanted to have sexual intercourse before marriage and why she felt that way. During this period Patient A and Dr Hughes sent messages to each other describing sexual acts and fantasies which they described as 'daydreams'. At the time, Patient A was still aged 17.

32. Dr Hughes attended Patient A's 18th birthday party on XXX May 2015, having been invited by her parents. The following weekend, XXX May 2015, Patient A visited Dr Hughes XXX and they had sexual intercourse on several occasions.

33. Patient A visited Dr Hughes again between 22 and 25 June 2015 and they had sexual intercourse several times. They had a discussion about marriage and the future of their

relationship, which they disagreed about. Following this visit, they agreed to take a break from the relationship over the summer holiday.

34. Following this break, Dr Hughes and Patient A met up several more times, including after XXX, however the relationship did not begin again. There was some further sexual activity in early 2016 but the relationship did not resume and there was not sexual intercourse. The messages and emails become less frequent over the course of 2016 and the last contact between them was an email from Patient A to Dr Hughes on 13 May 2018 asking to meet up, but Dr Hughes did not reply. Throughout this period, Patient A was XXX struggling XXX which she stated was a result of the relationship breaking down.

35. Patient A reported the matter to the Metropolitan Police in June 2020 and was interviewed on 4 January 2021. Dr Hughes was interviewed by police in April 2021 and provided a prepared statement. The investigation was closed with no further action against Dr Hughes.

Paragraph 1(a)

36. The Tribunal first considered whether Dr Hughes was in a professional position in relation to Patient A between 2011 and December 2013. There was no dispute that Dr Hughes had met Patient A in March 2011 when she was an inpatient at Bristol Royal Hospital for Children, and he was a fourth-year medical student undertaking a clinical placement. XXX The Tribunal found that had it not been for Dr Hughes' position as a medical student, he would not have met or begun to communicate with Patient A.

37. The Tribunal took into account the guidance which was relevant at the time, 'Medical students: professional values and fitness to practise', and found the following paragraphs to be relevant:

> *'11. Although medical students have legal restrictions on the clinical work they can do, they must be aware that they are often acting in the position of a qualified doctor and that their activities will affect patients. Patients may see students as knowledgeable, and may consider them to have the same responsibilities and duties as a doctor.*
> *…*
>
> *23. Medical students will have extensive contact with patients during their medical course. Although there are limits to these clinical encounters and students are supervised, patients may consider the student to be in a position of responsibility, and so may attach added importance to their opinions or comments.'*

38. The Tribunal noted that Patient A's initial contact with Dr Hughes via email related to her operation and his opinion on her condition more generally, for example, on 15 March 2012, Patient A wrote to Dr Hughes asking:

> *'Don't quite know why but [XXX] has reacted completely different to [XXX] than ever has before.*
> *Might have to ask you to help me a project that I've been asked to do due to helping with [XXX] when I know what I'm doing.*
> *Please Can quiz you about some medically things you may know about?'*

39. Dr Hughes replied to Patient A on 16 March 2012, and in response to her comment about XXX

40. Patient A replied to Dr Hughes on 24 March 2012 and provided a lengthy description of the impact that the XXX treatment had on her XXX. The Tribunal noted that throughout 2011 and 2013 Dr Hughes and Patient A regularly discussed the effect of her ongoing treatment and the efficacy of various other treatments, for example, Patient A sought Dr Hughes' opinion on the evidence supporting treatment with XXX and Dr Hughes replied offering his opinion about XXX.

41. The Tribunal found that Patient A was seeking Dr Hughes' opinions and comments because she viewed him as a knowledgeable person who had previously been involved in her care. The Tribunal therefore found that Dr Hughes was in a professional position in relation to Patient A during the period 2011-December 2013.

42. The Tribunal then considered whether Dr Hughes had used his professional position to pursue an improper emotional relationship with Patient A between 2011 and December 2013. The Tribunal first considered the contemporaneous evidence which was the emails that Dr Hughes and Patient A exchanged throughout 2011, 2012 and 2013.

43. The Tribunal was of the view that although Dr Hughes sent an email to Patient A on 16 March 2011 attaching her x rays, thereafter the majority of the email chains were started by Patient A. Dr Hughes initiated contact again on 9 April 2012 and 25 May 2012 to XXX Besides these occasions, all the other email chains were started by Patient A.

44. The Tribunal noted that when Dr Hughes did not reply for some time, as he often did not, Patient A would start a new email chain, requesting Dr Hughes' opinion or assistance

with something, for example, on 7 March 2013, Patient A emailed Dr Hughes and asked how his training was going as well as sending him more poems to review. The last email before that had been an unanswered email which Patient A sent to Dr Hughes on 28 December 2012. The Tribunal therefore found that the majority of the correspondence during this period was instigated by Patient A.

45. The Tribunal then considered the frequency of the emails. The Tribunal noted that although the correspondence was sustained for more than two years, there were periods where the contact dropped off and Dr Hughes did not reply, as well as periods where Patient A did not reply. There was no correspondence between April and June of 2011 following Patient A's discharge from hospital, nor between July and November 2011. The Tribunal identified other periods of more than 6 weeks in which there was no communication. As noted above, on most occasions, it was Patient A who initiated contact with Dr Hughes to end these periods of non-communication.

46. The Tribunal then considered the contents of the emails. The Tribunal noted that the initial emails in early 2011 were related to Patient A's hospital stay and surgery. Following a gap after her discharge, the emails resumed in June 2011 when Patient A requested XXX. There was then another significant gap until November 2011. Thereafter the emails became lengthier, and discussion expanded to include whether Patient A should study medicine and how difficult she might find it. There were often multiple topics covered in each email, but the Tribunal found that they generally related to school, University, and discussions of Patient A's condition and ongoing treatments. For example, on 6 December 2012, Dr Hughes emailed Patient A the following:

> *'Hi Patient A*
>
> *Well done on your [XXX], hope the rest go as well. I have now moved to General Surgery and am enjoying working for a great reg and consultant (though not quite as great as [XXX]*
>
> *Good to know re. alcohol gel and permanent marker, I will pass that on if patients are ever struggling to remove it.*
>
> *Glad you liked [XXX]*
>
> *Best,*

Cian Hughes'.

47. The Tribunal found that this reflected the general tone of the emails which Dr Hughes sent to Patient A. The Tribunal found that Dr Hughes did not bring up personal topics or ask personal questions, and he usually replied politely to Patient A's questions.

48. The Tribunal considered the GMC's submission that Dr Hughes and Patient A were sharing 'in jokes' within the emails and that this was a clear sign of a personal relationship developing between them. The Tribunal accepted that Patient A made references to Dr Hughes' green socks and the circumstances of their meeting in hospital. The Tribunal bore in mind that Patient A had been an inpatient for several weeks and it was evident from the continuing correspondence that she had made a connection with Dr Hughes. The Tribunal did not consider that this was inherently inappropriate and accepted Dr Hughes' evidence that he was grateful to Patient A for XXX, so he spent more time talking to her. The Tribunal found that it would be natural for people who spent a long period of time together – even in a professional relationship - to form 'in jokes' between themselves. The Tribunal reminded itself that the fact that the correspondence continued beyond Patient A's hospital stay was inappropriate, however it did not find that the inclusion of 'in jokes' showed that Dr Hughes was pursuing an emotional relationship with Patient A during that time.

49. The Tribunal noted that the email chain from March 2011 was forwarded to Patient A's mother, and on 3 August 2012 Dr Hughes suggested that Patient A '*at least mention'* to her parents that she was emailing him. Patient A replied on 4 August 2012 that she had told her parents she had emailed him to discuss medical school. The Tribunal found that this was evidence that Dr Hughes was not trying to hide his correspondence with Patient A from her parents.

50. When determining whether Dr Hughes had used his professional position to pursue an improper emotional relationship with Patient A, the Tribunal took into account that the instigation of the majority of the correspondence came from Patient A, that the correspondence was often infrequent, that Dr Hughes occasionally did not reply at all, that the contents of the emails was largely in relation to school, medicine and Patient A's treatment, and that Dr Hughes made no effort to hide the correspondence. The Tribunal considered the meaning of the word "pursue" and considered that it betokened a purposive following of Patient A, or Dr Hughes seeking out a relationship in a way which was not evident in the messages between Dr Hughes and Patient A at this stage in their relationship. The Tribunal considered that the fact the correspondence took place at all was inappropriate,

but it did not find evidence that Dr Hughes had intentionally pursued an improper emotional relationship with Patient A after her discharge from hospital and up to December 2013.

51. The Tribunal therefore found paragraph 1(a) not proved.

Paragraph 1(d)

52. The Tribunal first considered whether Patient A had developed feelings for Dr Hughes in April 2013. The Tribunal considered the email which Patient A sent to Dr Hughes on 20 April 2013:

> *'…*
> *Thank you very much for your comments about the poetry, they are very helpful ideas but I don't know what I'll do. I hope that you and everyone else will support me in whatever i choose to do with them, whether that's publishing them soon, later or never! At the moment I'm using 8 of them in my [XXX] exam piece. They've been really fun to write and I hope my studying doesn't get in the way of me writing more.*
>
> *I really appreciate the support you have given me over the last two years. I think you're probably the only medical person I know who doesn't seem to forget I'm still only 15 sometimes! I have to admit that I really miss having you around in meetings and surgical days (honestly I don't mind your cold stethoscope or big arrows) to translate the medical jargon, make me smile/laugh and realise that I'm not superhuman and get nervous about the prospect of future plans and surgery.'*

53. The Tribunal considered the tone of Patient A's email and was mindful that when it was read with the knowledge of how the relationship went on to develop, it was evident that Patient A had begun to develop feelings for Dr Hughes, whether or not she was aware of this herself. The Tribunal noted that Dr Hughes accepted in his oral evidence that he could see this now. However, the Tribunal was mindful that this paragraph of the Allegation related specifically to Dr Hughes' knowledge of Patient A's feelings at the time. The Tribunal then went on to consider whether Dr Hughes was aware from April 2013 that Patient A had developed personal feelings for him.

54. The Tribunal noted that while Patient A expressed that she missed Dr Hughes, she was clearly putting this in the context of missing having him around when she was in hospital to explain the procedures and treatments to her. The Tribunal found that it was possible that

Dr Hughes interpreted this email as a continuation of their earlier discussions about her condition and the assistance he had given her with medical terminology and research papers.

55. The Tribunal noted that later emails from Patient A develop a more personal tone, and it is possible that Dr Hughes became aware of Patient A's feelings before December 2013. For example, in an email on 17 July 2013, Patient A stated:

> *'Thank you, will miss you loads. Trying to be positive as much as I don't feel like it at the moment, but as my close friends have been saying it'll be okay.*
> *Have fun sailing!*
> *Will keep you posted on how it goes.*
> *Patient A'*

56. The Tribunal further considered that by April 2013, Patient A had sent Dr Hughes more than 50 poems, one of which it was agreed was clearly about Dr Hughes. The Tribunal found that with the knowledge of how the relationship went on to develop, this was further evidence that Patient A had developed feelings for Dr Hughes by April 2013. However, it considered Dr Hughes' responses to the poetry to be the best evidence of how he viewed it at the time. On 7 March 2013, Dr Hughes replied to Patient A and stated:

> *'…*
> *I read your new poems and they are fantastic, you have a real talent. But I'm not sure if I would publish them. I think they are in some ways quite private and personal, once you publish something you can never take it back out of the public domain. If I were you I would keep writing and save them, then in the future you could always publish a retrospective selection. But that's just my thoughts, and I'm quite a private person.'*

57. Dr Hughes further replied to Patient A's email set out at paragraph 52 above,

> *'I would absolutely support whatever you choose to do with your poetry, I didn't mean to sound like I was against the idea of publishing! You are a fantastic writer and that will stand to you whatever path you take in life.'*

58. The Tribunal found that Dr Hughes' response to the poetry was polite and focused on the publication of the poems rather than the contents of the poems. It was not clear from the emails that Dr Hughes had appreciated the significance of the poetry.

59. The Tribunal therefore concluded that, while it was apparent, with hindsight, that Patient A had developed feelings for Dr Hughes in April 2013, there was not clear evidence from his email responses that he was aware of this fact at the time. The Tribunal further found that in the email dated 20 April 2013, Patient A was not explicit about her feelings for Dr Hughes, and did not consider that the GMC had proved on the balance of probabilities that Dr Hughes was aware of Patient A's feelings at that stage.

60. The Tribunal found paragraph 1(d) not proved.

Paragraph 2(a)(i)

61. Having found paragraph 1(d) not proved, the Tribunal further found that paragraph 2(a)(i) was also not proved.

The Tribunal's Overall Determination on the Facts

62. The Tribunal has determined the facts as follows:

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

1. On or around 10 March 2011 you observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, you sent messages to Patient A between 2011 and November 2013 as set out in Schedule 1, which were inappropriate in that:

    a. you used your professional position to pursue an improper emotional relationship with Patient A;

    Determined and found not proved.

    b. the messages were not part of Patient A's medical care;

    Admitted and found proved.

    c. you sent the messages directly to Patient A and to no one else;

    Admitted and found proved.

    d. you were aware that Patient A had developed personal feelings for you from April 2013.

Determined and found not proved.

2. From December 2013 you used your professional position to pursue an improper emotional relationship with Patient A in that you sent messages to her, as set out in Schedule 1, which were inappropriate in that:

   a. you were aware that Patient A had developed personal feelings for you from either:

      i. April 2013; or

      Determined and found not proved.

      ii. December 2013;

      Admitted and found proved.

   b. the messages were not part of Patient A's medical care;

   Admitted and found proved.

   c. you sent the messages directly to Patient A and to no one else;

   Admitted and found proved.

   d. the nature of your messages became personal;

   Admitted and found proved.

   e. your messages became more frequent.

   Admitted and found proved.

3. You sent Patient A messages from 23 October 2014 to 2015 as set out in Schedule 1 with the intention of pursuing a sexual relationship with Patient A.

   Admitted and found proved.

4. You entered into a sexual relationship with Patient A in that you, on one or more occasions, from:

a. October 2014 kissed Patient A;

Admitted and found proved.

b. February 2015 engaged in sexual activity with Patient A;

Admitted and found proved.

c. 29 May 2015 engaged in sexual intercourse with Patient A.

Admitted and found proved.

5. Your actions at paragraph 3 were sexually motivated.

Admitted and found proved.

6. You knew that Patient A was vulnerable at all material times for the reasons set out in Schedule 2 below.

Admitted and found proved.

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.
To be determined.

Determination on Impairment - 17/01/2025

63. This determination will be handed down in private. However, as this case concerns Dr Hughes' misconduct a redacted version will be published at the close of the hearing.

64. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Hughes' fitness to practise is impaired by reason of misconduct.

The Evidence

65. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. This included the reflective statements provided by

Dr Hughes dated 30 January and 30 September 2024. In addition, the Tribunal received further evidence as follows.

66. The Tribunal also received in support of Dr Hughes 8 testimonials from colleagues, each of which it has read.

67. The Tribunal also received certificates for the following CPD courses which Dr Hughes has completed:

- Maintaining Professional Boundaries, 6 September 2024;
- Medical Ethics, 11 December 2020;
- Boundary violations and sexual exploitation: recognition, avoidance and management, 4 November 2020;
- Reflective Writing Skills for Appraisal and CPD, 27 November 2020; and
- Evidence of completion of Professional Competence Scheme for Royal College of Surgeons in Ireland.

Submissions

On behalf of the GMC

68. On behalf of the GMC, Ms Renton submitted that each of the paragraphs of the Allegation are not merely trivial or inconsequential, nor a temporary lapse or something excusable or forgivable. She submitted that Dr Hughes has not upheld the high standards of the profession and his actions constitute misconduct, which is serious for a number of reasons.

69. Ms Renton submitted that the misconduct is serious for the following reasons: Patient A's age, XXX, the nature of the sexual relationship, the impact on Patient A, Dr Hughes' approach to the guidelines and the departures from Guidance and Good Medical Practice (2006 and 2013, as amended) ('GMP 2006' and 'GMP 2013').

70. Before turning to the factors which increase the seriousness of the conduct, Ms Renton set out that Dr Hughes has no previous findings of impaired fitness to practise and he has admitted all aspects of the Allegation, save for the matters which were found not proved by the Tribunal.

71. Ms Renton submitted that Patient A's age has been identified as a known aspect of her vulnerability. She submitted that Patient A and Dr Hughes started communication when

Patient A was not yet 14 and Dr Hughes became a source of guidance: Patient A valued his opinion XXX. She submitted that once the iMessaging began, the topics expanded, and it is hard to quantify the magnitude of the impression that Dr Hughes left on Patient A. She submitted that Patient A grew from an adolescent into a young adult with the constant influence of Dr Hughes, as evidenced by the communication growing over more than six years. She submitted that Dr Hughes was a formative influence on Patient A's life. She submitted that the abrupt end of the relationship was and continues to be devastating to Patient A. She submitted that Patient A's age should be taken into consideration when assessing the other serious features of the case, in that Patient A was being placed in very adult situations when she lacked the maturity to be able to deal with the issues that arose.

72. In addition to Patient A's age, Ms Renton submitted that Patient A was vulnerable by XXX

73. When considering the sexual relationship, Ms Renton submitted that Patient A had very limited knowledge about sex XXX. Ms Renton submitted that as a result Patient A was entirely reliant on Dr Hughes to tell her what was and was not 'normal', XXX. XXX. Ms Renton set out Patient A's 'rules', including XXX. She submitted that Patient A had a clear reticence about having sex with Dr Hughes. She further set out that Patient A and Dr Hughes had discussed XXX.

74. Ms Renton set out that Patient A and Dr Hughes' messages in the days leading up to them having sex for the first time included frequent sexualised discussion about what was being imagined in what they referred to as 'daydreams'. She submitted that this would have put pressure on Patient A in the context of the power imbalance between the two. XXX. Ms Renton submitted that Dr Hughes too readily took patient A's messages about wanting sexual activity at face value. She submitted that as Dr Hughes was, at this time, a registered doctor and nine years Patient A's senior, he should have considered her 'flip-flopping' on the matter as a sign that she did not want to engage in sexual activity. She submitted that whilst Dr Hughes told Patient A that they could wait until she was 18, in the context of the imbalance of power that existed by virtue of Dr Hughes' age and relative sexual experience, it was understandable that Patient A would not readily decline on the age of turning 18. She further submitted that Patient A had been reassured that Dr Hughes saw the relationship leading to marriage, a state of mind Dr Hughes said he was also in, but the two had very different timescales. She submitted that the fact that Dr Hughes entered into a relationship with a former patient who was 18 years old XXX whilst he was nine years older and had sexual experience is a significant aggravating feature to the seriousness of the charges.

75. Ms Renton then set out the impact on Patient A. She submitted that the impact on her includes: a distrust of authority figures, medical professionals and medical appointments; XXX; a difficulty communicating, particularly about her wishes; a general mistrust of men outside her family, with a few exceptions; XXX. Ms Renton accepted that this, in some senses contrasted with the messages which Patient A sent at the time, however she submitted that Patient A was 17-18 years old and may not have been entirely honest as she was in love and trying to please Dr Hughes. As Patient A put it, she was '*desperate for him not to reject me*'. She submitted that the impact on Patient A is a feature which increases the seriousness.

76. Ms Renton then turned to Dr Hughes' interpretation of the guidelines. She submitted that Dr Hughes had described a great deal of reading on issues such as whether a doctor-patient relationship existed between him and Patient A; would the guidance permit a relationship with a previous patient, especially a paediatric patient; and would entering into a relationship with Patient A be a breach of criminal law.

77. Ms Renton submitted that the GMC do not submit that Dr Hughes understood the guidance and chose to ignore it. She submitted that Dr Hughes did not ignore the guidance, because he could not countenance that the relationship was contra to the spirit of the guidance. She submitted that Dr Hughes had placed too much emphasis on the word 'may' to justify the relationship. She further submitted that Dr Hughes discussed the guidance with Patient A and placed heavy reliance on her opinion of it. This was unfair to Patient A who was 17 at the time XXX, with limited knowledge of what the GMC was and why such guidance might exist. Ms Renton submitted that Dr Hughes did so to justify his view of the guidance but also to sound out the likelihood of Patient A making a complaint against him. Ms Renton submitted that the messages demonstrated that Patient A and Dr Hughes were clear before any sexual activity took place that they must wait until she was 18 to have sexual intercourse and that Dr Hughes had presumably conflated the criminal law relating to sexual activity in a position of trust with his regulatory requirements. She submitted that this "deliberate connivance" is an aggravating feature which is demonstrative of Dr Hughes' attitude at the time: that the purpose of the research which he undertook was to find a way to make the relationship happen, lacking insight that it may be inappropriate.

78. Turning to the relevant guidance at the time, Ms Renton referred to the 'Medical students: professional values and fitness to practise', as set out in the Tribunal's determination on facts. She submitted that this was relevant as it set out that the same professional boundaries applied to medical students at the time as to registered doctors and

Dr Hughes did not maintain those professional boundaries when he met Patient A. She further submitted that paragraph 25 of GMP 2006 is relevant:

> '*25 You must safeguard and protect the health and well-being of children and young people. '*

79. She submitted that Patient A was vulnerable XXX and Dr Hughes' decision to pursue a friendship and then a romantic relationship with Patient A did not safeguard her XXX. She further submitted that paragraph 53 of GMP 2013 is relevant, as admitted by Dr Hughes:

> *'53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.'*

80. She further submitted that the guidance 'Maintaining a professional boundary between you and your patient' (2013) is relevant as Dr Hughes considered it before entering a romantic relationship with Patient A. She set out that the following paragraphs are relevant:

> *'8 Personal relationships with former patients may also be inappropriate depending on factors such as:*
>
> > *a the length of time since the professional relationship ended (see paragraphs 9–10)*
> >
> > *b the nature of the previous professional relationship*
> >
> > *c whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable (see paragraphs 11–13)*
> >
> > *d whether you will be caring for other members of the patient's family.*
>
> *You must consider these issues carefully before pursuing a personal relationship with a former patient.*
>
> *9 It is not possible to specify a length of time after which it would be acceptable to begin a relationship with a former patient. However, the more recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate.*

10 The duration of the professional relationship may also be relevant. For example, a relationship with a former patient you treated over a number of years is more likely to be inappropriate than a relationship with a patient with whom you had a single consultation.

11 Some patients may be more vulnerable than others and the more vulnerable someone is, the more likely it is that having a relationship with them would be an abuse of power and your position as a doctor.

12 Pursuing a relationship with a former patient is more likely to be (or be seen to be) an abuse of your position if you are a psychiatrist or a paediatrician.

13 Whatever your specialty, you must not pursue a personal relationship with a former patient who is still vulnerable. If the former patient was vulnerable at the time that you treated them, but is no longer vulnerable, you should be satisfied that the patient's decisions and actions are not influenced by the previous relationship between you, and that you are not (and could not be seen to be) abusing your professional position.'

81. Ms Renton submitted that when considered alongside the guidance, the relationship with Patient A was inappropriate in that: whilst some years had elapsed since Patient A met Dr Hughes in hospital, the point at which the friendship commenced was when Patient A was 16 (just over the age of consent) and the romantic relationship commenced when she was 17. She further submitted that the previous relationship with Patient A was one of an observing medical student XXX, and Dr Hughes accepts that Patient A was vulnerable for the reasons set out by the GMC.

82. Ms Renton submitted that the following paragraphs of 'Maintaining Boundaries' (2006-2013) are relevant:

'5 You must not pursue a sexual relationship with a former patient, where at the time of the professional relationship the patient was vulnerable, for example because of mental health problems, or because of their lack of maturity.

6 Pursuing a sexual relationship with a former patient may be inappropriate, regardless of the length of time elapsed since the therapeutic relationship ended. This

is because it may be difficult to be certain that the professional relationship is not being abused.

7 If circumstances arise in which social contact with a former patient leads to the possibility of a sexual relationship beginning, you must use your professional judgement and give careful consideration to the nature and circumstances of the relationship, taking account of the following:

a. when the professional relationship ended and how long it lasted
b. the nature of the previous professional relationship
c. whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable
d. whether you will be caring for other members of the patient's family.

8 If you are not sure whether you are – or could be seen to be – abusing your professional position, it may help to discuss your situation with an impartial colleague, a defence body, medical association or (confidentially) with a member of the GMC Standards and Ethics team.'

83. Turning to the reputation of the medical profession, Ms Renton submitted that Dr Hughes has acknowledged that the impact of his action is not just on Patient A but on the wider public and profession. Ms Renton submitted that the guidance existed for a purpose and that by deviating from that Dr Hughes has undermined the public's trust in the profession.

84. In summary, Ms Renton submitted that the misconduct is of a very serious nature. Ms Renton then turned to the question of whether Dr Hughes' fitness to practise is impaired today. She submitted that Dr Hughes has in the past brought the medical profession into disrepute, as the public would be perturbed to hear of the relationship between Dr Hughes and Patient A and how it came to pass. She further submitted that Dr Hughes has in the past breached one of the fundamental tenets of the profession as he has acted contra to GMC guidance and GMP.

85. With regard to insight, remorse and remediation, Ms Renton submitted that the GMC accept that Dr Hughes has offered a heartfelt apology to Patient A in his evidence for the impact of his conduct on her. She also submitted that the GMC accept that Dr Hughes has undertaken training on maintaining professional boundaries and has tried to demonstrate insight into these matters, although he has also readily adduced what the impact was on him

too. She submitted that it is a matter for the Tribunal to consider the extent of Dr Hughes' insight, remorse and remediation.

86. Ms Renton submitted that the GMC remain concerned that there is a risk of repetition. She submitted that despite the CPD Dr Hughes has engaged in, he has described how whilst he was communicating with Patient A, he '*couldn't see the wood for the trees*'. Ms Renton submitted that he struggled to view the situation objectively and that this is a difficult situation to remediate. She submitted that Dr Hughes retains a clinical practice whilst working in a non-clinical role and the GMC remain concerned that should he again find himself to have powerful emotions towards a patient this may continue to cloud his judgement.

87. Turning to the overarching objective, Ms Renton submitted that all three limbs are engaged. She submitted that if the Tribunal consider that there is a risk of repetition, it should consider the impact of Dr Hughes' actions on Patient A - XXX. She further submitted that the public should have confidence that their medical treatment should not be used as an avenue to pursue personal and romantic relationships, particularly in circumstances where they have met as a paediatric patient. She submitted that Dr Hughes' actions have disturbed the natural and expected public confidence in the medical profession. Finally, she submitted that Dr Hughes has not upheld professional standards and conduct befitting a member of the medical profession: he has permitted professional boundaries to be breached and a finding of impairment would be in furtherance of this aspect of the overarching objective.

<u>On behalf of Dr Hughes</u>

88. On behalf of Dr Hughes, Ms Harris submitted that Dr Hughes accepts that the facts in the case amount to misconduct that is serious. She submitted that the Tribunal would need to consider where this case falls on a spectrum of seriousness and will need to assess the level of culpability to be attached to Dr Hughes' wrongdoing. She therefore went on to make some submissions on the seriousness of the evidence the Tribunal has read and heard.

89. Ms Harris submitted that Dr Hughes accepts his actions were in breach of relevant published guidance and he has apologised for the hurt and distress his actions have caused Patient A. She submitted that the misconduct can be separated into three periods: April 2011 to December 2013; December 2013 to October 2014, and October 2014 onwards.

90. With regard to the period April 2011 to December 2013, Ms Harris submitted that there can be no suggestion that Dr Hughes selected 13-year-old Patient A as someone he

wanted to a pursue a relationship with, and there is no suggestion of a sinister motive behind the communication in this period. She submitted that Dr Hughes has accepted throughout that he 'opened the door' for the inappropriate communication, but that this could be put into context. She submitted that the emails came from a good place and were well intended, that Dr Hughes was trying to be helpful to Patient A, that he asked her to inform her parents about the contact and XXX. She submitted that Dr Hughes accepts that he failed to maintain professional boundaries in these early stages but that this behaviour was at the lower end of the spectrum of seriousness. She submitted that Dr Hughes was not seeking a relationship at this stage and the significance of the conduct in this period is that it provided a stepping stone for what was to follow. She submitted that it did not occur to Dr Hughes that this was a breach of guidance at the time, and that this is clear from the contents of the emails.

91. Ms Harris further submitted that the Tribunal should take into account the stage of Dr Hughes' career at the time: that he is now 10-14 years older and vastly more experienced, that he has given sophisticated evidence both orally and in writing revealing mature reflection and developed understanding. She submitted that when assessing the misconduct in this case, the Tribunal should bear in mind that at the time Dr Hughes was extremely unwise, naïve and *'extremely emotionally immature'.*

92. Turning to the period from December 2013 to October 2014, Ms Harris submitted that Dr Hughes accepts that in this period he was pursuing a friendship with Patient A, who was, by now, 16. She submitted that while it is right to say that such a friendship should not have been pursued, it was lively, intellectual and mutually supportive at the time. She submitted that it is important to distinguish this case from other cases of inappropriate relationship. She submitted that while Dr Hughes accepts that there was a power imbalance and it is right to say he was influential on Patient A, this was not a controlling, coercive or destructive relationship.

93. With regard to the breach of guidance in this period, Dr Hughes' evidence was that while he accepts unequivocally now that it should not have happened, he simply did not recognise in this period that the guidance might be engaged. She submitted that it is clear from the message exchanges in this period that Dr Hughes had not initially contemplated the 'former patient' possibly arising from his position as a medical student and he was looking at Patient A as a friend who could not become a patient, rather than a patient who could not therefore be a friend. She submitted that Dr Hughes' state of mind at the time is central to the Tribunal's assessment of his personal culpability and the seriousness of the misconduct throughout. She submitted that Dr Hughes' evidence, which is supported by the messages, is

that he did not consider the guidance at this stage and as such this case should be distinguished from one where the registrant deliberately flouts the guidance.

94. Turning to the period from October 2014 onwards, Ms Harris submitted that with respect to Dr Hughes' approach to the guidance from this period onwards, it is plain the idea of a romantic relationship triggered Dr Hughes to consider the guidance and the possibility that Patient A may be a 'former patient'. She submitted that there is no basis for the Tribunal to reject Dr Hughes' evidence that he got the guidance very wrong and did so in circumstances where he wrongly persuaded himself the relationship was admitted. She submitted that the Tribunal should accept his explanation which is consistent with his messaging at the time.

95. With regard to the messages about XXX, Ms Harris submitted that Dr Hughes took XXX reference to him '*[XXX]'* to be an extremely crude and very inappropriate attempt at levity which he did not appreciate. She submitted that this was not how Dr Hughes considered Patient A, who he considered his equal and submitted that he was very much in love with her.

96. Ms Harris submitted that while Dr Hughes accepted absolutely that there was an imbalance of power in the relationship before it went sour, it was a very loving relationship which had developed quickly 'online' and the reality did not live up to the expectation. She submitted that whilst acknowledging there should never have been a relationship at all, it is important to note that Dr Hughes does not face any allegation that he coerced or pressured Patient A into a relationship or any sexual activity within that relationship, and any finding of such would be inconsistent with the thousands and thousands of messages.

97. With regard to the end of the relationship, Ms Harris submitted that if there is any lingering concern that Dr Hughes had an ulterior motive in letting Patient A down gently, the Tribunal should not reach that conclusion. She submitted that the messages at the time show that Dr Hughes was hoping they may get back together or at least be friends. She submitted that Dr Hughes wanted to provide support and to help to Patient A. XXX.

98. With regard to the criminal investigation, Ms Harris submitted that this is not a case where the GMC allege that criminal conduct has taken place and the conduct in this case must not be elevated or equated with criminal offending. She submitted that the Tribunal must make its findings on the basis of the case that has been put before it.

99. In summary Ms Harris submitted that Dr Hughes accepts that the conduct in this case amounts to misconduct, which is serious, however she submitted that the Tribunal should take into account that Dr Hughes was a very young, naïve, inexperienced, newly qualified, emotionally immature doctor who got it very wrong indeed. She submitted that this case should and could be distinguished from cases involving senior clinicians who very deliberately flouted the guidance by entering relationships with current and former patients in far more clear-cut circumstances.

100. Turning to the matter of impairment, Ms Harris submitted that the misconduct in this case is remediable. She accepted that certain types of misconduct are not so easily remediated but she submitted that in the circumstances of this case, Dr Hughes was at a very early stage of his career and as such his misconduct is capable of remedy. Ms Harris set out Dr Hughes' current professional position: that he is employed in a research role at Google and no concerns have been raised about his work there. She further set out the positive testimonials received on Dr Hughes' behalf from current and former colleagues and managers.

101. Ms Harris submitted that since the complaint was received in 2020 Dr Hughes has undertaken targeted remedial work and extensive reflection. She set out the courses that Dr Hughes has attended and provided reflections on. This included professional boundaries, oaths and duties of a doctor and medical ethics, as well as a wide range of reading on relevant topics. She submitted that as well as this learning, Dr Hughes has reflected extensively on his misconduct and she took the Tribunal to the reflective statements provided by Dr Hughes, noting in particular the reflections on the impact his actions have had on Patient A.

102. Ms Harris submitted that as a result of this remedial work, Dr Hughes has developed exceptional insight into the misconduct in this case. She submitted that Dr Hughes has a full and clear understanding of the following: the serious nature of the misconduct, the importance of maintaining professional boundaries, how misconduct, in particular sexual misconduct, can impact an individual doctor's professional position, how it can impact on how patients see doctors as a whole, how it can damage public confidence in the profession, and the impact on the regulator. Ms Harris submitted that Dr Hughes has demonstrated this insight by the following: his full engagement with the GMC, his acceptance of wrongdoing at an early stage, his formal admissions in this hearing, his unreserved and repeated apologies, his expressions of regret and remorse, his impressive reflections, and his readiness to disclose

the circumstances of the case to employers, colleagues and friends as set out in the testimonials.

103. With regard to the risk of repetition, Ms Harris submitted that Dr Hughes' appreciation of the seriousness and wide impact of his actions reduces the risk of repetition. She further submitted that the facts of this case are very specific, and it is highly unlikely that Dr Hughes will find himself in the same position again. She submitted that in the unlikely event that he did, his remediation work, reflection, and experience has left him well equipped to deal with potential boundary violations. Finally, she submitted that these events have been out of character for Dr Hughes, as evidenced by the fact that 10 years have now passed and Dr Hughes has not repeated the misconduct, nor had it occurred in the past. She further submitted that this is evidenced in the testimonials which repeatedly state that the conduct is out of character for Dr Hughes.

104. In summary Ms Harris submitted that given the nature and age of the misconduct, it is capable of remediation, Dr Hughes has done all he can to remedy it and there is no risk of repetition.

105. Finally, Ms Harris turned to the matter of public interest in cases of misconduct. She acknowledged that the wider public interest is engaged in every case that comes before a Tribunal and that even if the Tribunal were to find that the misconduct has been remedied, it must go on to consider the public interest. She submitted that the Tribunal must bear in mind that it is considering whether Dr Hughes' fitness to practise is currently impaired. She further reminded the Tribunal that not every case of misconduct requires a finding of impairment simply to mark the public interest. She submitted that the Tribunal should take into account the age of the misconduct, the nature of the misconduct, including the nuanced factual matrix, the loving nature of the relationship before it came to an end, the stage of his career that Dr Hughes was at, that Dr Hughes did not deliberately flout the guidance, that ten years have followed with no further complaints of any type, and that Dr Hughes has an otherwise unblemished career. She submitted that full remediation has taken place and there is no risk of repetition. She submitted that the Tribunal should consider the above when determining whether a finding of impairment is required in the public interest.

The Relevant Legal Principles

106. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

107. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct and then whether the finding of that misconduct could lead to a finding of impairment.

108. The Tribunal must determine whether Dr Hughes' fitness to practise is impaired today, taking into account Dr Hughes' conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

109. The test for impairment was established by Dame Jane Smith in the 5th Shipman report as repeated in the case of CHRE v NMC & Grant 2011 EWHC 927 Admin: Do the findings show that the doctor's fitness to practice is impaired in the sense that:

a. They have, in the past/or are liable in the future to act to as to put a patient or patients at unwarranted risk of harm.
b. They have, in the past/or are liable in the future to bring the medical profession into disrepute.
c. They have, in the past/or are liable in the future to breach one of the fundamental tenets of the medical profession.
d. They have, in the past/or are liable in the future to act dishonestly.

110. In this case the GMC submits that Dr Hughes' fitness to practice is impaired on the second and third bases – that his misconduct has brought the profession into disrepute and has breached fundamental tenets of the medical profession.

The Tribunal's Determination on Impairment

Misconduct

111. The Tribunal bore in mind that Dr Hughes has accepted that his actions amount to misconduct. The Tribunal therefore considered the course of conduct as a whole when assessing the seriousness.

112. The Tribunal accepted Ms Renton's submissions that Dr Hughes' conduct was a serious departure from paragraph 25 of GMP 2006, which was relevant during the period 2011-2013, and paragraph 53 of GMP 2013, which was relevant for the remaining period of the relationship. The Tribunal also found, as Dr Hughes accepted, that the relationship was a departure from the guidance on maintaining professional boundaries which was applicable to medical students at that time.

113. The Tribunal then considered the factors which may increase the seriousness of the misconduct. The Tribunal first considered Patient A's age at the time. The Tribunal was concerned by the significant age gap between Dr Hughes and Patient A, in particular that Patient A was 13 at the time they met and 17 when the romantic relationship and sexual activity began. The Tribunal found that this created an imbalance of power in the relationship that must have led to Patient A feeling pressured within the relationship.

114. The Tribunal considered the submission that the seriousness of the misconduct is reduced by Dr Hughes' position as a medical student at the beginning of the friendship and as a junior doctor at the time of the romantic and sexual relationship. The Tribunal reminded itself that guidance at the time, as set out in its decision on facts, stated clearly that medical students are to be held to the same standards as registered doctors and they must be aware that patients may see them as being in the same position of responsibility. The Tribunal found that it could not be right, therefore, that Dr Hughes' relatively junior position significantly diminished the seriousness of his actions, as the guidance was clear that his youth and inexperience were not relevant in his interactions with patients.

115. The Tribunal then considered the other factors which increased Patient A's vulnerability beyond her age. XXX

116. XXX

117. When considering Dr Hughes' approach to the guidance at the time, the Tribunal found that Dr Hughes was clearly aware that the relationship had the potential to breach the guidance, as he went away and researched the matter. The Tribunal considered the messages which Dr Hughes sent to Patient A on 4 November 2014 (at which point the romantic relationship was at an early stage):

> *'Okay, [XXX] is right that you should be super-careful. Though I will do my utmost not to hurt you, and that is very much my intention. It's also very much in my interest not to, as you pretty much have the power to end my career if I do. …'*
>
> *'So, this turned into a bit of an essay, sorry, but I think it's important that you understand it…*
>
> *The GMC guidance, just so you know them are here: http://www.gmc-uk.*

org/guidance/ethical_guidance/21170.asp#vulnerable_patient

Whether or not these apply probably depend on whether or not you are a former patient of mine. Which is why I asked you if you felt a Dr-Patient relationship existed, which I know you feel didn't. It's not clear to me if a medical student can have a Dr-Patient relationship, but at the same time they are held to account to the same ethical standards as Doctors, so best to play it on the safe side and act as if they do.

They say that "Whatever your specialty, you must not pursue a personal relationship with a former patient who is still vulnerable." While I don't think you'd describe yourself as vulnerable, everyone is automatically considered vulnerable until they turn 18. (Up until which point your parents could also complain on your behalf about my behaviour). [XXX] may also make you "vulnerable" in the eyes of the GMC after that point, but at least at that point your parents can't complain on your behalf without your consent.

It's because of all of this that I've said we can't consider pursuing a personal relationship (what a wonderfully unromantic phrase) until you're 18. And even then if you ever feel that in retrospect I have abused a position of power/authority please tell me, as that is very much not my intention!

It's funny, in my mind the above rules actually swing any potential power imbalance very much the other way. What do you think?'

118. The Tribunal further took into account Dr Hughes' response to questions in cross-examination and questions from the Tribunal:

'Is this a case where you knew the relationship may be at odds with guidance or is it a case where you were desperate to make it work and you wanted it to be permitted?

My state of mind was as I'd said before: I wanted reassurance that it was okay - I wasn't looking to do something untoward. I knew that what we were proposing was something that was close to the wrong side of that line. At the same time, I can see now I desperately wanted us to find a rationalisation that made it okay. That as I read it [the guidance] at the time [the relationship] may or may not have been appropriate,

it was in that space. Unfortunately at one point one of her friends asks 'is this legal' and the entirely separate question crosses our mind of criminal law. Is this against the law? I then started to conflate the two things not fully appreciating what I do now that as a registered professional I'm held to a higher standard in addition to that question. I didn't think at the time that any complaint would be upheld, I thought I was just on the right side of the line.

…

Were you trying to fit your scenario to the guidance?

I was trying desperately to fit my scenario to the guidance. I wanted a way through the guidance I wanted a binary yes or no from the guidance.

[Your friend told you] 'Three letters Cian: GMC', you said it's not that you're ignoring her advice, you plan on changing her opinion. Were you looking for opinions but only the ones you wanted to hear?

I was looking to be reassured that it was okay. I was not in a state of mind at that point in time where I was equally open to opinions on both sides. I wish I hadn't tried to change this person's opinion and had listened to everything she had to say and take it on board. I was hoping I could find a way that our scenario could be permissible within the guidance.'

119. The Tribunal understood from Dr Hughes' background that he was involved in research and was used to working with senior clinicians and referring to them for advice. The Tribunal found, however, that in this situation, Dr Hughes did not seek the advice of senior clinicians. The Tribunal was concerned that when Dr Hughes found himself in the position of considering a romantic relationship which could have major ramifications for him, his career, and Patient A, he did not seek out those opinions – rather, he looked for reassurance that it was alright for him to have the relationship.

120. Furthermore, when Dr Hughes did seek opinions from colleagues his own age, one friend and fellow doctor advised him against the relationship, stating '*three letters Cian: GMC*'. The Tribunal further noted that XXX had spoken negatively about the relationship, remarking to Dr Hughes that XXX and Dr Hughes had taken this as an unwelcome joke, rather than the wake-up call which the Tribunal considered it ought to have been. The Tribunal

noted that rather than listening to these opinions and reconsidering his actions, Dr Hughes sought to convince his friends that the relationship was permissible. The Tribunal was concerned that this showed that Dr Hughes was looking for validation rather than seeking an independent opinion.

121. The Tribunal further noted that Dr Hughes' approach to the guidelines was to identify that they presented a potential barrier to the relationship, but then to interpret them in a way which allowed the romantic relationship. The Tribunal found that Dr Hughes had, in effect, persuaded himself that the parts of the guidance which prohibited this relationship did not apply, and instead Dr Hughes had focused on the 'may' element of the guidance that he interpreted as giving him leeway because he wanted to have a relationship with Patient A. The Tribunal noted that in his oral evidence, Dr Hughes accepted that, at the time, he had taken a partial view of the guidance which allowed him to do what he wanted to do. The Tribunal bore in mind that the GMC did not present the case against Dr Hughes on the basis that he had deliberately flouted the guidance, but found that it was a serious matter that Dr Hughes was at least aware of the risk that he was in breach of the guidelines, but continued to advance the relationship anyway.

122. In summary, the Tribunal found that a number of factors significantly increased the seriousness of the misconduct:

- Patient A's age at the time, in particular that she was 17 when the romantic and sexual relationship began;
- XXX
- The power imbalance in the relationship as a result of Dr Hughes' professional position and the age difference; and
- Dr Hughes' approach to the guidelines: that he was aware of the risk that the relationship was in breach of the guidelines but then looked for reassurance that the relationship was permissible, rather than the contrary view before progressing the relationship.

123. The Tribunal found that members of the profession would find Dr Hughes' conduct deplorable: in particular that he did not account for Patient A's vulnerability XXX. The Tribunal further found that members of the public, fully informed of the facts of the case, would be shocked and concerned by Dr Hughes' conduct.

124. The Tribunal has therefore concluded that Dr Hughes' conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment

125. The Tribunal, having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct, Dr Hughes' fitness to practise is currently impaired.

126. The Tribunal first considered whether this was misconduct which was remediable. The Tribunal bore in mind that sexual misconduct is more difficult to remediate, but not impossible. It took into account Ms Harris' submission that Dr Hughes' junior position and inexperience should be accounted for when considering whether the conduct is remediable.

127. The Tribunal noted that Dr Hughes has undertaken a range of courses on professional boundaries and medical ethics. The Tribunal also noted that these courses were undertaken over the last four years and had not been done solely in anticipation of this hearing. The Tribunal found that the courses were targeted and appropriate to the issues raised in the case.

128. The Tribunal then considered the reflections which Dr Hughes has produced as a result of the courses he has undertaken. The Tribunal found that Dr Hughes has made full and appropriate reflections on his actions, including on how he would manage a similar situation in the future. The Tribunal noted his reflective statement, in which he stated:

> *'On reflection, it is clear to me that I was more open to the possibility of a relationship at that time given my personal circumstances – being young and newly qualified in a new city, an ill friend, professional pressure from training and exams, being single and alone over the Christmas period following the loss of my grandmother. This is a significant contrast to my position today, married, living near extended family and friends, and with an established job. These current circumstances along with my overall maturity as a person today further increase my confidence that I am not at risk of this scenario ever happening again.*
>
> *Receiving this complaint has been a very traumatic personal experience that has caused me to deeply reflect on my behaviours. I recognise that I can never know whether [Patient A] was truthful to me about her feelings during our relationship, and*

that those feelings changed over the years that have passed influenced by conversations with others; or if indeed her feelings were always as she expresses them now. But in either case I feel deeply personally responsible and sorry for how she feels about our relationship today.

…

[XXX]

In summary, I am confident that through both my experience gained through years of practice and my focused continuing professional development following this complaint I am well equipped today should I ever find myself in a similar situation. And should I do so, I know that I would not face it alone, but would be supported by colleagues and mentors. I believe myself to now be very well educated around the potential for any position of trust, even that of the trust placed in a student, to be abused either intentionally or accidentally. As a consequence I feel very well equipped to avoid any situation where there is a risk of this.'

129. The Tribunal found that Dr Hughes' reflections showed learning from both his own experience and from the CPD he has participated in. The Tribunal was mindful that while his reflections focused on his actions as a medical student when he met Patient A, this initial relationship opened the door to further communication and it was appropriate that Dr Hughes had reflected on this at length. The Tribunal noted that Dr Hughes' evidence of his insight and reflection focused mainly on boundary violations and how to prevent these and only to a limited degree on how he would respond to having feelings of attraction towards a patient. However, it was mindful that the sexual attraction between Dr Hughes and Patient A developed in the context of an ongoing relationship. The Tribunal found that Dr Hughes has shown significant insight into his misconduct, that he has learnt from that situation and would be able to prevent the initial boundary violation in the future.

130. The Tribunal was mindful that it is difficult to remediate the damage which has been done to public confidence in the profession by Dr Hughes' actions, and while he has undertaken personal remediation, such matters are inherently difficult to remediate. However, the Tribunal was satisfied that, by his learning and reflections, Dr Hughes remediated to the extent which is in his power.

131. The Tribunal then considered the risk of repetition in the future. The Tribunal bore in mind that more than ten years have passed since the relationship ended and there has been no suggestion that Dr Hughes has engaged in any similar behaviour, nor had he done so before this. The Tribunal further found that over that period Dr Hughes has matured significantly and has gained experience in his practice as evidenced from the testimonials. The Tribunal, as set out above, found that Dr Hughes now has the skills to avoid such boundary violations in the future and was more aware than most of inappropriate personal contact with patients. Finally, the Tribunal found that these proceedings, which have lasted several years, will have been a chastening experience for Dr Hughes and he will want to avoid being in this position again.

132. The Tribunal was concerned, however, by Dr Hughes' attitude to the guidelines at the time. It was concerned that Dr Hughes had conducted research into the guidelines but had taken into account those parts which he believed allowed the romantic and sexual relationship to develop, while persuading himself that the parts of the guidance which forbade the relationship did not apply. The Tribunal took this into account when balancing the factors which might lead to a repetition of the behaviour in the future.

133. In conclusion, the Tribunal was mindful of Dr Hughes' previous approach to the guidelines, however it found that his significant remediation, well developed insight and experience of these proceedings mean that the risk of repetition of the misconduct is low.

134. The Tribunal then turned to the test as set out in the case of *Grant*. The Tribunal found that Dr Hughes has, in the past, brought the profession into disrepute. The Tribunal found that although the misconduct occurred more than ten years ago, it was of such an unacceptable and serious nature that members of the profession and the public would be shocked and concerned.

135. The Tribunal further found that Dr Hughes has breached a fundamental tenet of the profession. As set out above, Dr Hughes' misconduct was a serious departure from the guidelines in place at the time. Furthermore, the Tribunal found that Dr Hughes' misconduct had breached the fundamental tenet that patients must be able to trust their doctors and have confidence that they will not use their professional position to instigate a personal relationship, especially with regard to young and vulnerable people whom they met as paediatric patients.

136. The Tribunal took into account the submission which Ms Harris made that there is not always a need to make a finding of impairment to mark the public interest. The Tribunal took into account the specific factors which Ms Harris had drawn to its attention which differentiate this case from other more serious cases of sexual misconduct. The Tribunal noted the opinion of Mr Justice Sales in the case of *Yeong v GMC* [2009] EWHC 1923 and considered that the situation described was relevant to the current case:

> *'Where a medical practitioner violates such a fundamental rule governing the doctor/patient relationship as the rule prohibiting a doctor from engaging in a sexual relationship with a patient, his fitness to practise may be impaired if the public is left with the impression that no steps have been taken by the GMC to bring forcibly to his attention the profound unacceptability of his behaviour and the importance of the rule he has violated; that, where a panel considered that fitness to practise was impaired for such reasons, the efforts made by the practitioner to address his problems and to reduce the risk of such misconduct in the future might be of far less significance than in other cases, such as those involving clinical errors or incompetence; and that, since the reasons given by the panel in the present case were primarily based on its view that the case called out for a finding of impairment…so as to reaffirm the proper standards of behaviour in respect of relations between medical practitioners and patients, its reasoning that remedial action taken by the doctor did not adequately address that concern could not be faulted.'*

137. The Tribunal took into account the specific facts of this case, but found that, nevertheless, the serious nature of its findings means that it is necessary to mark the misconduct with a finding of impaired fitness to practise, otherwise public confidence in the profession and the upholding of proper professional standards would be undermined.

138. The Tribunal therefore found that Dr Hughes' fitness to practise is impaired.

Determination on Sanction - 04/06/2025

139. Having determined that Dr Hughes' fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

140. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

141. The Tribunal received further evidence at this stage of the hearing which included:

- Supplemental bundle
- Second supplemental bundle

Submissions

On behalf of the GMC

142. Ms Renton submitted that this Tribunal may consider that the appropriate and proportionate sanction in this case is one of erasure.

143. Ms Renton set out the mitigating factors that the Tribunal identified in its determination on impairment. She recognised that Dr Hughes has attempted to personally remediate through relevant courses, though it was noted these focused mainly on boundary violations and were more limited on how to respond to feelings of attraction towards a patient. Ms Renton added that Dr Hughes has expressed regret and remorse, remediated the damage to public confidence to the extent it is in his power and has made full and appropriate reflections, demonstrating insight. Further, she noted that the Tribunal was of the view that there is a low risk of repetition. Ms Renton stated that Dr Hughes' compliance with conditions, his cooperation with the GMC investigation, the lapse of time since the incidents and his provision of references were additional mitigating factors. Further, Ms Renton acknowledged that Dr Hughes was at the beginning of his career at the time of the allegations. However, as per paragraph 30 of the Sanctions Guidance, in cases involving serious misconduct (e.g., predatory behaviour or serious dishonesty), the stage of a doctor's career has limited influence on sanction. While Ms Renton submitted that the GMC does not allege predatory behaviour, the Tribunal's findings reflect very serious misconduct.

144. Ms Renton submitted that the main aggravating feature is the circumstances surrounding the event. The Tribunal noted in their determination on impairment that although the misconduct occurred over ten years ago, it was of such an unacceptable and serious nature that members of the profession and the public would be shocked and concerned. Further, the Tribunal outlined features that significantly increased the

seriousness of the misconduct, including Patient A's age (17 when the romantic and sexual relationship began), XXX, which Dr Hughes acknowledged he was aware of, the power imbalance due to Dr Hughes' professional position and age difference and Dr Hughes' approach to the guidelines—he was aware of the risk of breaching them but seeking reassurance rather than contrary advice before proceeding.

145. Ms Renton submitted that this case falls into the category of cases that indicate more serious action is likely to be required. She invited the Tribunal to address Dr Hughes' abuse of a professional position, emphasising that trust is the foundation of the doctor-patient relationship and that doctors must not use their position to pursue improper relationships. Ms Renton submitted that this lies at the heart of the Allegation against Dr Hughes—had he not met Patient A as a medical student, he would not have been able to pursue the relationship. She further submitted that this was a highly inappropriate relationship with a very vulnerable person and pursuing such a relationship with a vulnerable patient is an aggravating factor likely to require more serious action.

146. Ms Renton submitted that this is not an exceptional case where "no action" would be appropriate, given the Tribunal's finding that the misconduct was extremely serious. She further submitted that conditions are also not appropriate in this case as Dr Hughes' misconduct involved abuse of professional position, making conditions unsuitable. Additionally, Dr Hughes now works and resides in a different jurisdiction, raising practical concerns about enforceability. For these reasons, conditions are not an appropriate sanction.

147. Ms Renton submitted that, while some factors relating to suspension apply (e.g., low repetition risk, potential remediation, insight), suspension as a sanction would be insufficient given the Tribunal's finding that impairment was necessary to uphold public confidence and professional standards. The seriousness of the misconduct warrants a more severe sanction.

148. Ms Renton reminded the Tribunal that it had found that Dr Hughes ignored guidance and colleagues' advice, advancing the relationship despite awareness of the risks. She added that erasure may be appropriate even without patient risk if necessary to maintain public confidence particularly where a doctor shows blatant disregard for professional safeguards. Ms Renton outlined the criteria for erasure which she considered applied in this case, including the misconduct being a serious GMP departure which was fundamentally incompatible with being a doctor, a deliberate/reckless disregard for GMP, an abuse of position and/or the exploitation of a patient's vulnerability. Though erasure is the most

severe sanction, Ms Renton submitted that it is proportionate and necessary given the Tribunal's findings in its determination on impairment: that the public and profession would find Dr Hughes' conduct "deplorable" and "shocking."

On behalf of Dr Hughes

149. Ms Harris submitted that Dr Hughes acknowledges the seriousness of the Allegation against him but erasure from the medical register is disproportionate. Given the unique circumstances of this case—including the Tribunal's findings, Dr Hughes' exemplary professional record, and the significant passage of time since the events—a suspension would sufficiently uphold public confidence while allowing him to contribute in the future to the medical profession.

150. Ms Harris outlined that Dr Hughes works full-time at Google Health in AI health research and has no immediate plans to return to clinical practice. However, registration remains crucial for roles in his field, including Clinical Safety Officer work or regulatory compliance in medical technology. She reminded the Tribunal of the testimonials it had before it from colleagues (e.g., consultants, Google Health executives) which attest to Dr Hughes' clinical competence, impeccable conduct, and character. Notably, she submitted, there are no concerns about his behaviour toward patients or women, underscoring that the misconduct was an isolated incident. Ms Harris went on to set out the remediation Dr Hughes has completed, including professional boundaries and ethics training, Advanced Trauma Life Support (ATLS) certification and his compliance with Irish Medical Council CPD requirements. Ms Harris also noted that Dr Hughes has demonstrated full cooperation with proceedings, including early admissions and efforts to spare Patient A any further distress which might have been caused if she were required to give evidence in these proceedings.

151. Ms Harris submitted that the Tribunal previously found Dr Hughes demonstrated "full and appropriate" reflections, "significant insight," and a "low risk of repetition." His latest reflections (post-Stage 2) further confirm a deep understanding of the misconduct, particularly the imbalance of power and boundary violations, sincere remorse and acknowledgment of harm to Patient A, and proactive remediation, including ongoing learning and adherence to ethical guidelines.

152. Ms Harris submitted that suspension aligns with the GMC's Sanctions Guidance (February 2024) ('SG'). She submitted that the Tribunal has to consider proportionality and the "least restrictive sanction" principle (para 20) favours suspension over erasure. She also

stated that suspension serves as a deterrent while recognising Dr Hughes' remediation (SG paragraphs 91–93).

153. Ms Harris outlined the mitigating Factors in this case (SG paragraphs 24–49). She submitted that Dr Hughes has demonstrated that he has insight and the Tribunal's determination on impairment confirm his "well-developed" insight. She submitted that Dr Hughes has shown extensive, timely efforts to remediate (e.g., courses, reflections) deemed effective by the Tribunal and this began as soon as he learnt of the Allegation against him. Dr Hughes has no prior misconduct and an unblemished record aside from this case. At the time of the events, Dr Hughes was a medical student/junior doctor and Ms Harris submitted that this *"junior status"* at the time meant that remediation was more likely to be achievable. Finally, it has been over a decade since the incidents, with no recurrence.

154. Ms Harris contended that erasure was unwarranted because, in this case, there were distinguishing features from typical "erasure" cases. She submitted that there had been no blatant disregard for guidance as the Tribunal found in its determination on impairment that Dr Hughes had considered the guidance but had "*persuaded himself*" that the relationship was permissible, rather than deliberately flouting rules. She submitted that Dr Hughes has not demonstrated predatory behaviour as the relationship between him and Patient A was mutual and emotionally supportive, albeit improper. Patient A initiated early contact, and the Tribunal dismissed allegations of exploitation during the initial period. Dr Hughes did not coerce Patient A. Therefore, Ms Harris submitted, Dr Hughes' misconduct falls at the less severe end of the spectrum of sexual misconduct.

155. Ms Harris urged the Tribunal to consider Dr Hughes' exceptional professional contributions and the public interest in retaining his skills. She submitted that a determination of suspension would be sufficient to address the Tribunal's concerns about public confidence in the profession and upholding professional standards for the profession. She reminded the Tribunal of its own findings in its determination on impairment that there had been significant remediation and that the risk of repetition was low. She submitted that a suspension—potentially with a review period—would balance public confidence, professional standards, and Dr Hughes' rehabilitative progress while erasure would be disproportionate given the nuanced facts and the extent of Dr Hughes' insight, apology and remediation.

The Tribunal's Determination on Sanction

156. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its own judgement. In so doing, it has given consideration to its

findings of fact, its findings of misconduct and impaired fitness to practise and the submissions made by Ms Renton on behalf of the GMC and Ms Harris on behalf of Dr Hughes. The Tribunal also paid particular attention to the 'Sanctions Guidance' (SG) and relevant paragraphs contained therein.

157. When considering sanction, the Tribunal must again have particular regard to the statutory overarching objective:

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

158. The Tribunal must consider the objective as a whole and should not give excessive weight to any one limb.

159. 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. In making its decision, the Tribunal also had regard to the principle of proportionality, and it weighed Dr Hughes' interests with those of the public.

160. Before considering what action, if any, to take in respect of Dr Hughes' registration, the Tribunal considered the aggravating and mitigating factors in this case.

Mitigating factors

161. The Tribunal considered and accepted the mitigating factors advanced by the parties during their submissions on sanction: by Ms Renton at Para 6 of the GMC's submissions and by Ms Harris at paragraphs 22 to 34 of her submissions on behalf of Dr Hughes.

162. Additionally, the Tribunal considered it significant to note that whilst the relationship was improper and arose because Dr Hughes had met Patient A through his professional position, it had not developed into an emotional or physical relationship until a considerable time after Dr Hughes' professional involvement with Patient A ceased.

163. Accordingly, the Tribunal considered the following to be mitigating factors in this case:

- Dr Hughes made admissions at the outset of the hearing
- Dr Hughes has made sincere apologies to those involved in his misconduct
- Dr Hughes has completed a wide range of appropriate CPD courses
- The Tribunal determined that Dr Hughes had remediated his misconduct to the extent that it was in his power to do so
- The Tribunal has seen a range of testimonials from colleagues stating that Dr Hughes is a competent doctor, and his contributions are highly valued
- The Tribunal was not aware of any other complaints which had been made about Dr Hughes either before or after the misconduct which is the subject of this hearing
- The Tribunal considered the lapse of time. The incidents took place over ten years ago and the Tribunal considered that Dr Hughes had demonstrated increased maturity since that time
- Dr Hughes cooperated with the police investigation and the GMC investigation.

Aggravating factors

164. The Tribunal considered whether there were any aggravating features to the misconduct and bore in mind the risk of 'double-counting' features of the misconduct which it had previously taken into account when assessing seriousness. The Tribunal did not identify any aggravating features which went beyond the serious nature of the misconduct as found at the impairment stage.

165. The Tribunal considered that the following were serious features of the misconduct:

- Patient A's age at the time, in particular that she was 17 when the romantic and sexual relationship began;
- XXX, which Dr Hughes accepted he was aware of at the time;
- The power imbalance in the relationship as a result of Dr Hughes' professional position and the age difference; and
- Dr Hughes' approach to the guidelines: that he was aware of the risk that the relationship was in breach of the guidelines but then looked for reassurance that the relationship was permissible, rather than the contrary view before progressing the relationship.

166. The Tribunal has taken these factors into account in considering the appropriate sanction under the SG. It considered each sanction in ascending order of severity, starting with the least restrictive.

No action

167. The Tribunal first considered whether to conclude the case by taking no action. Taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. The Tribunal determined that given its findings there are no exceptional circumstances in this case and that it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

168. The Tribunal next considered whether to impose conditions on Dr Hughes' registration. In so doing, it bore in mind that any conditions imposed would need to be appropriate, proportionate, workable, and measurable. Neither party suggested that conditions were appropriate or workable in this case.

169. In the light of its overall findings, the Tribunal determined that it would not be possible to formulate a set of appropriate or workable conditions which would adequately address Dr Hughes' misconduct. In any event, the Tribunal concluded that a period of conditional registration would not be a sufficient or proportionate sanction to satisfy the public interest, particularly as Dr Hughes' misconduct amounted to serious departures from GMP.

Suspension

170. The Tribunal then considered whether an order of suspension would be appropriate and proportionate in these circumstances.

171. The Tribunal has borne in mind paragraphs 91, 92, 93 and 97 of the SG

> *'91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in*

that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

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 (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*

93 *Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions…*

…

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

a *A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.*

…

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

f *No evidence of repetition of similar behaviour since incident.*

g *The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

172. The Tribunal determined that Dr Hughes' misconduct was serious and warranted a significant response to mark its gravity. In its findings regarding impairment the Tribunal had found (at paragraph 61 & 62 of its determination on impairment):

> *"61. … that members of the profession would find Dr Hughes' conduct deplorable: in particular that he did not account for Patient A's vulnerability [XXX]. The Tribunal further found that members of the public, fully informed of the facts of the case, would be shocked and concerned by Dr Hughes' conduct.*
>
> *62. The Tribunal has therefore concluded that Dr Hughes' conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct."*

173. The Tribunal considered the relevant paragraphs of the SG that indicate when a case is one in which more serious action is required:

> *'**142** Trust is the foundation of the doctor-patient partnership. Doctors' duties are set out in paragraph 86 of Good medical practice and in the more detailed guidance Maintaining personal and professional boundaries and Ending your professional relationship with a patient.*
>
> ***143** Doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.*
>
> ***144** Personal relationships with former patients may also be inappropriate depending on:*
>
> ***a** the nature of the previous professional relationship*
>
> ***b** the length of time since it ended (doctors must not end a professional relationship with a patient solely to pursue a personal relationship with them – see Maintaining personal and professional boundaries)*
>
> ***c** the vulnerability of the patient (see paragraphs 145–146)*
>
> *…*

145 Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as:

[XXX]

b being a child or young person aged under 18 years

…

146 Using their professional position to pursue a sexual or improper emotional relationship with a vulnerable patient is an aggravating factor that increases the gravity of the concern and is likely to require more serious action against a doctor.'

174. The Tribunal considered that these paragraphs were relevant because Dr Hughes used his professional position to engage in an improper relationship with a vulnerable patient and considered that this required the Tribunal to take serious action.

175. The Tribunal considered whether Dr Hughes' misconduct was so grave that it was incompatible with his continued registration as a doctor (para 108). In this regard the Tribunal bore in mind the seriousness of its findings and the overarching objective. It specifically had regard to relevant paragraphs of 109 of the SG, which provide:

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

a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

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

d Abuse of position/trust…

e Violation of a patient's rights/exploiting vulnerable people…

f Offences of a sexual nature, including involvement in child sex abuse materials

…
l putting their own interests before those of their patients…'.

176. The Tribunal considered the GMC's submission at para.28 of Ms Renton's submissions (referring to these paragraphs in SG) that Dr Hughes had shown a 'blatant disregard' for the guidance around inappropriate relationships and that this was a matter which was incompatible with Dr Hughes' continued registration. The Tribunal rejected this submission because its findings at the impairment stage had been that Dr Hughes did consider the guidance at the time he was considering entering a relationship with Patient A, but that he had persuaded himself that the guidance permitted the relationship. The Tribunal accepted Ms Harris' submission on behalf of the doctor that this was an important distinction, and it concluded that Dr Hughes had not blatantly disregarded the guidance as submitted by the GMC.

177. The Tribunal considered that Dr Hughes had abused his professional position and entered into an improper relationship with a vulnerable patient who he had met in a professional capacity. The Tribunal however, did not consider, bearing in mind the nature of the relationship revealed by the messaging between Dr Hughes and Patient A, that Dr Hughes had exploited Patient A's vulnerability. The Tribunal also bore in mind that the relationship had not developed during Dr Hughes' professional contact with Patient A – had this been the case, the Tribunal considered that the misconduct would have been more serious. However, the Tribunal also bore in mind the significant impact Dr Hughes' misconduct has had on Patient A.

178. Having carefully considered the options before it, the Tribunal reached the conclusion that the facts of this case were finely balanced and that there were a number of serious factors within the misconduct which could denote that erasure would be the appropriate sanction. However, the Tribunal bore in mind the mitigating features: particularly Dr Hughes' admissions and apology; his well-developed insight and remediation and his remorse. The Tribunal accepted Ms Harris' submission on behalf of Dr Hughes that this was a factually nuanced case and that it could be distinguished from other cases of sexual misconduct where erasure was required.

179. Accordingly, having looked at matters in the round, the Tribunal concluded that this case was not one where the misconduct was '*fundamentally incompatible with continued registration*' and that erasure would be a disproportionate response.

180. The Tribunal had further regard to the testimonials which show that Dr Hughes is a highly regarded, well liked and competent doctor. The Tribunal therefore considered that it was also in the public interest to allow an otherwise good and experienced doctor to remain on the register.

181. The Tribunal considered that it was essential to maintain the integrity of the medical profession, and Dr Hughes' behaviour was unacceptable. A strong message must be sent that such conduct was unacceptable, thereby reinforcing the standards expected of medical professionals and ensuring a deterrent for similar behaviour in the future.

182. In light of the above, the Tribunal determined that a period of suspension would be an appropriate and proportionate sanction balancing Dr Hughes' interests with those of the public. This would have the sufficient deterrent effect of sending a signal to Dr Hughes, the profession and the public that his misconduct was unbefitting of a registered doctor and would not be tolerated.

183. The Tribunal determined therefore that an order of suspension was required in this case. It then went on to determine the length of the suspension.

Length of Suspension

184. In determining the length of the suspension, the Tribunal had regard to paragraphs 99 to 102 of SG and the table following paragraph 102.

185. The Tribunal has set out its rationale for imposing a suspension in the wider public interest in order to maintain confidence in the profession and mark proper professional standards.

186. The Tribunal considered the aggravating factors in this case and acknowledged that this was a serious departure from the principles set out in GMP which came close to requiring a sanction of erasure. The Tribunal was of the view that there was a necessity to impose a meaningful period of suspension to uphold the public interest. The Tribunal was satisfied that imposing the maximum period of 12 months suspension was appropriate.

187. Accordingly, the Tribunal determined to suspend Dr Hughes' registration for a period of 12 months.

Review

188. The Tribunal determined to direct a review of Dr Hughes' case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought either by Dr Hughes or the GMC.

189. The Tribunal wishes to clarify that, at the review hearing, the reviewing Tribunal will be assisted by any evidence from Dr Hughes, including:

- Further reflection
- Evidence that he has maintained his medical skills and knowledge
- Any other information that he considers will assist the reviewing tribunal.

Determination on Immediate Order - 04/06/2025

190. Having determined to suspend Dr Hughes' registration for a period of 12 months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Hughes' registration should be subject to an immediate order.

Submissions

<u>On behalf of the GMC</u>

191. Ms Renton referred the Tribunal to paragraphs 172 and 178 of the Sanctions Guidance.

192. Ms Renton submitted that this was a case that was finally balanced, and she noted that the Tribunal had found that the case was close to the threshold for ordering erasure. Ms Renton suggested that the Tribunal should consider that this was in the upper scale of seriousness, particularly looking at the level of departure from GMP.

193. Ms Renton referred to the Tribunal's determination on sanction and submitted that the reasoning behind the suspension imposed related to maintaining the integrity of the medical profession. She stated that it is in the public interest to impose an immediate order based on the facts and the level of seriousness of this case.

On behalf of Dr Hughes

194. Ms Harris submitted that there are no issues of patient safety or issues around Dr Hughes as an individual. She stated that an immediate order in this case may only be imposed if the Tribunal considers it is in the public interest. She submitted that the Tribunal has determined that, whilst a serious sanction is required to mark the public interest, to maintain integrity and to send out a message, the public interest does not require Dr Hughes to be removed permanently from the medical register. She noted that the Tribunal set out in its determination on sanction that it is in the public interest that Dr Hughes remains on the register, albeit suspended.

195. Ms Harris submitted that by imposing a 12-month substantive suspension, a message will be sent out to the profession, integrity will be maintained, and the public interest will be marked regardless of when the suspension starts. She reminded the Tribunal that Dr Hughes does not hold a licence to practise in the UK currently.

The Tribunal's Determination

196. The Tribunal had careful regard to the submissions made by the parties and to the guidance in the SG including paragraphs 172 and 178:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being*

made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

197. The Tribunal bore in mind that there are no patient safety concerns in this case and that the risk of repetition was low. The Tribunal noted that Dr Hughes was not undertaking clinical practice, does not currently practise as a doctor in the UK, and there have been no issues relating to this misconduct in his practice for over a decade.

198. The Tribunal was also mindful of the public interest but was of the view that as there were no patient safety issues, the public interest could be met by the imposition of the significant 12-month substantive suspension.

199. Therefore, acknowledging the seriousness of the case, but noting the low risk of repetition, the Tribunal determined that an immediate order was not necessary in this case.

200. This means that Dr Hughes' registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal.

201. The interim order is hereby revoked.

202. That concludes this case.

ANNEX A – 15/01/2025

Application to amend the Allegation under Rule 17(6)

203. This determination will be handed down in private. However, as this case concerns Dr Hughes' misconduct a redacted version will be published at the close of the hearing.

204. On behalf of the GMC, Ms Renton made an application under Rule 17(6) of the Fitness to Practise Rules (2004, as amended) ('the Rules') to split paragraph 1 into paragraph 1 and 2, and to add paragraph 6, as follows:

1. On or around 10 March 2011 you observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, ~~you used your professional position to pursue an improper emotional relationship with Patient A in that you sent messages to Patient A between 2011 and 2016~~ you sent messages to Patient A between 2011 and November 2013 as set out in Schedule 1, which were inappropriate in that:

   a. you used your professional position to pursue an improper emotional relationship with Patient A;

   b. the messages were not part of Patient A's medical care;

   c. you sent the messages directly to Patient A and to no one else;

   d. from April 2013 you became aware that Patient A had developed personal feelings for you;

   ~~e. from 31 December 2013:~~

      ~~i. the nature of your messages became personal;~~

      ~~ii. your messages became more frequent;~~

   ~~f. you knew that Patient A was vulnerable for the reasons set out in Schedule 2 below.~~

2. From December 2013 you used your professional position to pursue an improper emotional relationship with Patient A in that you sent messages to her, as set out in Schedule 1, which were inappropriate in that:

a. you were aware that Patient A had developed personal feelings for you from:

i. April 2013;

ii. December 2013;

b. the messages were not part of Patient A's medical care;

c. you sent the messages directly to Patient A and to no one else;

d. the nature of your messages became personal;

e. your messages became more frequent.

6. You knew that Patient A was vulnerable at all material times for the reasons set out in Schedule 2 below.

Submissions

On behalf of the GMC

205. On behalf of the GMC, Ms Renton submitted that separating paragraph 1 of the Allegation into paragraphs 1 and 2, as set out above, would split the Allegation into two time periods. Ms Renton submitted that it is the GMC's position that from 2011 onwards, Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A and that this formed a course of conduct which continued through to 2013 and beyond. She submitted that there is a distinction between Dr Hughes' conduct in the two identified time periods.

206. Ms Renton submitted that the Case Examiners considered all of the emails sent from 2011 to the latter part of 2013 (when Dr Hughes qualified as a doctor) and commented as follows:

> *'Again we note that Dr Hughes did not initiate the rounds of correspondence, [XXX]. The emails mainly related to Patient A's questions about careers and what it was like to train as a doctor. The emails were friendly but reinforced the respective positions of Patient A as a young person and former patient and Dr Hughes as a qualified doctor. The emails did not contain any romantic, sexual or otherwise inappropriate content.'*

207. Ms Renton submitted that the GMC do not seek to argue that the contents of the messages were inappropriate, rather that the fact of the messaging was inappropriate. To this end, the GMC has identified four reasons as to why the messages were inappropriate:

- That Dr Hughes used his position to pursue an improper emotional relationship with Patient A – Ms Renton submitted that it is the GMC's case that an improper emotional relationship developed between Patient A and Dr Hughes as a result of his abuse of his position, in that they were only emailing as a consequence of his role as a medical student. Furthermore, Ms Renton submitted that the consistent progression of emails between Patient A and Dr Hughes shows a clear development of an emotional relationship, with emails discussing personal matters, surgery, exams, and that Dr Hughes became an emotional support for Patient A.
- Ms Renton submitted that the wording of the proposed paragraph 1(a) was previously contained within the 'stem' of paragraph 1 and that this will assist the Tribunal in making a decision which goes to the heart of the Allegation – the degree of the inappropriateness of the correspondence, without being contingent on Dr Hughes' having used his professional position to pursue an emotional relationship. She submitted that having this element of the Allegation removed from the stem means that the Tribunal can consider all of the evidence and the aspect of the allegation without the paragraph failing due to this requirement being in the stem.
- The messages were not part of Patient A's medical care – Ms Renton submitted that this is evident from the contents of the messages and to include this sub-category would be of no detriment to Dr Hughes.
- The messages were sent directly to Patient A – Ms Renton submitted that this is evident from the messages and again would be of no detriment to Dr Hughes.
- Dr Hughes was aware that Patient A had developed personal feelings for him from April 2013 – Ms Renton submitted that there is evidence available which shows that Patient A was developing feelings for Dr Hughes in April 2013. She noted an email in which Patient A described Dr Hughes as a support to her, that he is 'special' in that he treats her like a 15-year-old, and that she misses him being around during her treatment. She submitted that this sub-paragraph of the Allegation is contained within the current Allegation and therefore is not a substantive change in the GMC position such that there is a risk of injustice.

208. With regard to paragraph 2 of the Allegation, Ms Renton referred the Tribunal to the comments of the Case Examiner, who stated:

'We conclude that in late 2013 and 2014 Dr Hughes engaged in frequent messaging, communication was encouraged by Dr Hughes, and the content of the messages became more personal. Dr Hughes' correspondence with Patient A regularly referenced his position as a doctor and as someone who had become involved with her when he was a medical student and she was a young patient undergoing surgery; he had knowledge of her personal situation and health because of the way in which they met and the privileged access he had to a child patient in those circumstances. He also had knowledge gained from the ongoing communication he had with her since their first meeting in 2011. Based on the bundle of messages, we take the view that there is a realistic prospect of establishing that the messages sent by Dr Hughes to Patient A were inappropriate and that Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A.'

209. Ms Renton submitted that the 'stem' of this paragraph is to demonstrate the GMC's position that this is continuing a course of conduct which began in 2011, however that things developed in 2013. She submitted that the GMC adopts the position of the Case Examiners that there was an improper emotional relationship between Patient A and Dr Hughes, and it would not have existed had it not been for the professional position which he was in.

210. Ms Renton submitted that the sub-paragraphs of paragraph 2 of the Allegation set out the reasons why the messages were inappropriate. She submitted that while it is the GMC's position that Dr Hughes would have been aware that Patient A had personal feelings for him from April 2013, December 2013 is set out as an additional occasion on which Dr Hughes would have known of Patient A's personal feelings. She submitted that this date has been identified as it is on 31 December 2013 that Dr Hughes and Patient A begin exchanging iMessages, which was to be the format in which their romantic relationship developed. She further submitted that the messages were inappropriate in that they were not part of Patient A's medical care, they were sent to Patient A and no one else and the nature of the messages became personal and more frequent. She accepted that these facts were not in dispute with Dr Hughes.

211. Ms Renton noted that the referral from the Case Examiners set out explicitly that they did not feel it necessary to create such a distinction (between the period 2011-2013 and 2013-2015) and referred all of the messages between Dr Hughes and Patient A at the Rule 7 stage. She referred to the Case Examiners decision which stated,

'Based on the bundle of messages, we take the view that there is a realistic prospect of establishing that the messages sent by Dr Hughes to Patient A were inappropriate and that Dr Hughes used his professional position to pursue an improper emotional relationship with Patient A.'

212. In summary, Ms Renton submitted that there would be no injustice to Dr Hughes if the Tribunal were to amend the Allegation. She submitted that in amending the Allegation the GMC have sought to clarify their position to assist the Tribunal with how they put their case and to allow for the Tribunal to make more discrete findings, rather than be hampered by overly broad allegations. She submitted that these amendments would allow the Tribunal to come to a fairer and more focused determination, whatever the outcome may be.

213. With regard to the addition of paragraph 6 of the Allegation, Ms Renton submitted that the wording mirrors the wording currently in paragraph 1 of the Allegation, however due to the proposed amendment to split paragraph 1 into two paragraphs, it is necessary to have this as an additional paragraph which specifies that it covers both date periods. She submitted that this does not add any new complexion to the case and is simply a form of drafting to account for the other amendments.

<u>On behalf of Dr Hughes</u>

214. On behalf of Dr Hughes, Ms Harris submitted that the application was opposed. She set out to the Tribunal that this new proposed Allegation was the fourth version of the Allegation to be provided since Dr Hughes' case was referred to the MPTS. She submitted that this application to amend the Allegation had been made at the 11th hour before the commencement of the hearing and the GMC should have made this application earlier. She submitted that Dr Hughes and his representative have made every effort to ensure the case is prepared efficiently and resolved expeditiously without the need for Patient A to give evidence. She further noted that there have been delays in providing the bundle of messages to the Tribunal.

215. With regard to the application to split paragraph 1 of the Allegation into two paragraphs, Ms Harris submitted that this appears to be unnecessarily complicated. She set out that there is no objection to the removal of the words '*you used your professional position to pursue an improper emotional relationship*' from the stem of paragraph 1 and it is accepted that Dr Hughes' communication with Patient A after her discharge was inappropriate. She submitted that Dr Hughes does not accept, however, that between April 2011 and late 2013 he was pursuing a relationship with Patient A.

216. Ms Harris submitted that adding the words 'you used your professional position to pursue an improper emotional relationship' as a sub-paragraph of paragraph 1 was opposed. She submitted that this appears to be a modification of the Allegation by the GMC and they now allege that Dr Hughes was pursuing 'a relationship', the nature of which is now undefined. She submitted that the GMC has stated that this was an improper emotional relationship, but this is not what the Allegation now states. She further submitted that the messages do not support the allegation that Dr Hughes was pursuing a relationship with Patient A during this period, rather that Patient A was initiating contact with Dr Hughes. She submitted that this allegation is inconsistent with the finding made by the Case Examiner that Dr Hughes did not initiate correspondence, stating,

> *'…we note that Dr Hughes did not initiate the rounds of correspondence, [XXX], the emails mainly related to patient A's questions about careers and what it was like to train as a doctor. The emails were friendly but reinforced the respective positions of Patient A as a young person and former patient and Dr Hughes as a qualified doctor. The emails did not contain any romantic, sexual or otherwise inappropriate content.'*

217. She submitted that this can be contrasted with the observation that the Case Examiner made in relation to the messages from late 2013 onwards,

> *'We conclude that in late 2013 and 2014 Dr Hughes engaged in frequent messaging, communication was encouraged by Dr Hughes, and the content of the messages became more personal'*

218. Ms Harris submitted that the objection to the inclusion of 1(a) is unfair to Dr Hughes because it would be a procedural irregularity for a matter to become part of the Allegation after the Case Examiner has concluded that it did not occur. Finally, she submitted that Dr Hughes accepts that the messaging was inappropriate in any event.

219. With regard to proposed paragraph 2, Ms Harris submitted that paragraph 2(a)(i) is a repetition of paragraph 1(d) and as such should not be permitted as matter of law. She submitted that if the Tribunal were to find paragraph 1(d) proved, then that would form part of the factual background when it came to consider paragraph 2. She further submitted that while 2(a)(i) is presumably intended as an alternative to paragraph 2(a)(ii), it is not drafted as such.

220. In response to Ms Harris' submission that it would be procedurally unfair to include paragraph 1(a) in the Allegation following the Case Examiners decision that it was not part of Dr Hughes' conduct, Ms Renton submitted that the case was referred by the Case Examiner on the basis of the whole bundle of messages which included the period April 2011-late 2013. She submitted that this meant the Case Examiner had clearly concluded that there was a realistic prospect of establishing that Dr Hughes had used his professional position to pursue an improper relationship with Patient A from April 2011. She submitted that while the GMC accepts the difference in communication between the two periods, the case has been referred from the point of 2011 and it is now a matter for this Tribunal to determine at what point Dr Hughes' did or did not use his professional position.

The Relevant Legal Principles

221. The GMC apply to amend the Allegation which Dr Hughes faces. Rule 17(6) of the Rules states:

> *'Where, at any time, it appears to the Medical Practitioners Tribunal that—*
> *(a) the allegation or the facts upon which it is based and of which the practitioner has been notified under rule 15, should be amended; and*
> *(b) the amendment can be made without injustice, it may, after hearing the parties, amend the allegation in appropriate terms.'*

222. The Tribunal may wish to consider the following matters:

- Whether the amendments sought substantially alter the nature of the allegations and/or the evidence to be presented to the Tribunal.
- The stage at which the amendments are sought.
- Whether any prejudice or injustice is caused to the doctor by the proposed amendments.

The Tribunal's Determination

223. The Tribunal first considered the application to split paragraph 1 into two paragraphs. The Tribunal found that paragraph 1, in its current form, would potentially have created difficulties when it made its decision on the facts. It was concerned that the wording of the paragraph would have made it difficult for a clear decision on the facts to be produced, and it prevented Dr Hughes from making admissions to some of the facts, that he was otherwise willing to make.

224. The Tribunal considered the proposed new paragraphs 1 and 2 and found that the wording clarified the case which the GMC was intending to put to Dr Hughes. It further found that breaking the Allegation down into the two time periods would enable it to make a clear decision on that facts that can be easily interpreted by all parties and the public.

225. The Tribunal further found that the proposed paragraphs 1 and 2 did not introduce any new matters, as all the sub-paragraphs had previously either been contained in the stem of paragraph 1 or were contained in other sub-paragraphs. They therefore found that the proposed amendment did not substantially alter the Allegation against Dr Hughes.

226. The Tribunal was mindful that the application to amend the Allegation had been made late in the process and the GMC had changed the Allegation repeatedly. However, it took into account that the proposed amendment was not significantly different from the previous Allegation and would not impact on the nature of the case against Dr Hughes. The Tribunal therefore found that the lateness of the application did not in itself create an injustice to Dr Hughes.

227. The Tribunal considered Ms Harris' submission that paragraph 1(a) should not be included in the amended Allegation. The Tribunal was not persuaded that the Case Examiner had intended to exclude the Allegation that Dr Hughes used his professional position to pursue a relationship with Patient A between 2013 and 2015. The Tribunal accepted Ms Renton's submission that the referral to the MPTS had been made on the basis of the entire bundle of messages covering the period 2011-2015. The Tribunal was mindful that the Case Examiner had drawn a distinction between the two periods in some comments, however it found that this distinction was now reflected in the proposed separation of paragraph 1 into two paragraphs, each covering the different time periods. The Tribunal therefore found that it would not be unfair to Dr Hughes to include paragraph 1(a), as the Case Examiner had clearly referred the entire time period to be considered and it clarified the matters to be determined.

228. With regard to paragraph 1(d) and 2(a)(i) and (ii), the Tribunal accepted that these paragraphs contained a degree of duplication, but noted that they needed to be considered alongside the different stems in these allegations: new allegation 1 related to the Doctor's relationship with Patient A up to November 2013, whereas new allegation 2 related to the period from December 2013 onwards. The Tribunal considered that this was an appropriate way to divide the allegations and that the duplication of the words in these paragraphs did not give rise to any unfairness to Dr Hughes. It did, however, find that paragraphs 2(a)(i) and

(ii) were intended to be in the alternative to each other and therefore should be set out as such. It determined to add the words 'either' and 'or' to the paragraph to better reflect the intention of the drafting.

229. The Tribunal found that it was necessary to amend the Allegation according to the GMC application, with the addition of making 2(a)(i) and (ii) in the alternative, in order to promote and maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of that profession.

230. The Allegation will therefore be amended as follows:

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

1. On or around 10 March 2011 you observed a procedure on Patient A (a minor) at Bristol Royal Hospital for Children. After Patient A's discharge in April 2011, you sent messages to Patient A between 2011 and November 2013 as set out in Schedule 1, which were inappropriate in that:

    a. you used your professional position to pursue an improper emotional relationship with Patient A;

    To be determined.

    b. the messages were not part of Patient A's medical care;

    To be determined.

    c. you sent the messages directly to Patient A and to no one else;

    To be determined.

    d. you were aware that Patient A had developed personal feelings for you from April 2013.

    To be determined.

2. From December 2013 you used your professional position to pursue an improper emotional relationship with Patient A in that you sent messages to her, as set out in Schedule 1, which were inappropriate in that:

a. you were aware that Patient A had developed personal feelings for you from either:

i. April 2013; or

To be determined.

ii. December 2013;

To be determined.

b. the messages were not part of Patient A's medical care;

To be determined

c. you sent the messages directly to Patient A and to no one else;

To be determined.

d. the nature of your messages became personal;

To be determined.

e. your messages became more frequent.

To be determined.

3. You sent Patient A messages from 23 October 2014 to 2015 as set out in Schedule 1 with the intention of pursuing a sexual relationship with Patient A.

To be determined.

4. You entered into a sexual relationship with Patient A in that you, on one or more occasions, from:

a. October 2014 kissed Patient A;

To be determined.

b. February 2015 engaged in sexual activity with Patient A;

To be determined.

c. 29 May 2015 engaged in sexual intercourse with Patient A.

To be determined.

5. Your actions at paragraph 3 were sexually motivated.

To be determined.

6. You knew that Patient A was vulnerable at all material times for the reasons set out in Schedule 2 below.

To be determined.

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct.

To be determined