PUBLIC RECORD

Dates: 03/02/2025 - 20/03/2025
17/03/2025 - 19/03/2025
16/04/2025 - 24/04/2025

Doctor: Dr Christopher STEER

GMC reference number: 2565750

Primary medical qualification: MB ChB 1982 University of Birmingham

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

Summary of outcome

Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Claire Lindley
Lay Tribunal Member:	Ms Glenys Evans
Registrant Tribunal Member:	Dr Anup Singh

Tribunal Clerk:	Mr Sewa Singh Mr Michael Murphy (17 – 18 March 2025)

Attendance and Representation:

Doctor:	Present, not represented
Doctor's Representative:	None
GMC Representative:	Mr Terence Rigby, Counsel
Special Counsel:	Mr Daniel Mullin, Counsel (To 11/02/2025)

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 - 19/03/2025

1. This determination will be read in private. However, as this case concerns Mr Steer's misconduct, a redacted version will be published at the close of the hearing to ensure the anonymity of Patient A.

Background

2. Mr Steer qualified in 1982 at the University of Birmingham, after which he moved to King's College London, where he worked for three years undertaking research in fertility. Mr Steer subsequently undertook his registrar rotation at St George's Hospital in London, and his senior registrar rotation at the Royal Free Hospital and North Middlesex hospital where he worked for a year.

3. Mr Steer subsequently joined the Princess Royal University Hospital (PRUH) in Kent, where he continued to work for the remainder of his career in the NHS. During this time, Mr Steer was selected by the Royal College of Gynaecologists (RCOG) as an accredited trainer in minimal access surgery (operative hysteroscopy and operative laparoscopy), including the most advanced category (e.g. laparoscopic and hysteroscopic removal of fibroids as a day case).

4. At the time of the alleged events, Mr Steer was an experienced consultant obstetrician and gynaecologist working at a number of different hospitals, both in the NHS and private practice, namely the PRUH in Kent, Sloane Hospital, Blackheath Hospital and Chelsfield Park Hospital.

5. Mr Steer retired from the NHS in 2019 but continued to practise privately, and during the Covid-19 pandemic returned to the NHS, working as a Bank Consultant Obstetrician and Gynaecologist.

6. There are a number of allegations against Mr Steer arising from a complaint made by Patient A to the GMC on 3 June 2020.

7. Patient A was a XXX at Chelsfield Park Hospital and first met Mr Steer when she was referred to him in December 2015 as a patient. She had worked with him on one or two occasions but did not know him very well. It is firstly alleged that on 19 December 2015, Mr Steer operated on Patient A and performed a hysteroscopy and laparoscopic uterine nerve ablation (LUNA), when there was no clinical indication to

do so, with the LUNA procedure being a course of action over and above the treatment of any endometriosis.

8. Patient A later started working with Mr Steer more frequently and it is then alleged that, between February 2016 and September 2016, Mr Steer exchanged a number of WhatsApp messages with Patient A, offering her a private scan free of charge, commenting on how attractive she was, and inviting her to meet him for drinks and also to visit his home. During that time, it is alleged that Mr Steer pursued an improper emotional relationship with Patient A, which was sexually motivated.

9. Between November 2016 and April 2017, it is then alleged that Mr Steer engaged in a sexual relationship with Patient A whilst she remained his patient, during which time he conducted further procedures and follow up appointments. He attended her XXX.

10. On 18 February 2017, Patient A went to the Accident and Emergency (A&E) Department at the PRUH. It is claimed by Patient A that she told Mr Steer, who was on duty, that she did not want him to perform the surgery because of their relationship, and that Mr Steer promised her that he would not do so. Whilst still on the ward, Patient A found out that Mr Steer had been involved in the surgery. About 10 days later she went to his home where he removed the stitches.

11. There are then later allegations against Mr Steer relating to an appraisal form that he filled out at the hospital, in which he failed to declare that his registration was subject to an open GMC investigation and also suggested that a complaint made against him had been resolved when he knew this was untrue. It is alleged that Mr Steer's actions in this respect were dishonest.

The Outcome of Applications made prior to the case opening

12. Mr Steer did not attend at the start of the hearing and had made an application for an adjournment by email. The Tribunal considered this application under Rule 29 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), and heard submissions from Mr Terence Rigby, counsel for the GMC. The application was refused in private session, and the Tribunal's full decision is included at Annex A.

13. The Tribunal then granted an application, made by Mr Rigby, pursuant to Rule 40 to proceed with the case in Mr Steer's absence. The application was granted in private session and the Tribunal's full decision on the application is included at Annex B.

14. Mr Rigby made an application for Patient A to be granted anonymity under Rule 35(4) of the Rules, which was granted by the Tribunal. Mr Steer was not present for this application. The Tribunal determined that the identity of this witness should not be revealed in public.

The Outcome of Applications Made during the Facts Stage

15. Mr Steer attended the hearing on 12 February 2025 (day 8). He was unrepresented. At the end of the GMC case, and before Mr Steer gave his evidence, he requested that the witness statements of two nurse colleagues, Ms F and Ms J, be admitted to the Tribunal. He explained that they were unable to attend the Tribunal to give oral evidence, because they were both working in an outpatient clinic, and it was half term, and other nurses were on leave and so that they could not leave the clinic. There were no objections from the GMC, and the Tribunal granted Mr Steer's request, in accordance with Rule 34(1) of the Rules.

16. There were two experts in this case - Mr B, who provided reports and gave oral evidence on behalf of the GMC, and Professor C who had made a report on behalf of Mr Steer. Mr Steer requested that Professor C's expert report, dated 9 March 2023, and the joint expert report, dated 16 March 2023, be admitted to the Tribunal. He explained that he could not afford to pay for Professor C's attendance to give oral evidence. There were no objections from the GMC, and the Tribunal granted Mr Steer's request, in accordance with Rule 34(1) of the Rules. Mr Steer also requested that some further medical guidance documents be considered at this stage, again which was granted by the Tribunal.

The Allegation and the Doctor's Response

17. The Allegation made against Mr Steer is as follows:

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

1. On 19 December 2015 you:

    a. inappropriately operated on Patient A ('Procedure One'):

        i. as you performed a hysteroscopy when there was no clinical indication; To be determined

        ii. as you performed a laparoscopic uterine nerve ablation:

            1. as a course of action over and above treatment of any endometriosis; To be determined

            2. when it was not clinically indicated; To be determined

        b. failed to obtain informed consent from Patient A for Procedure One. To be determined

2. Between February 2016 and September 2016, whilst Patient A remained your patient, you:

a. engaged in conversations with Patient A by way of WhatsApp messages in which you:

i. offered to do Patient A a private scan free of charge, or words to that effect; Admitted and found proved

ii. commented on how attractive you found Patient A; To be determined

iii. invited Patient A to meet you for drinks; To be determined

iv. on one or more occasion asked Patient A to go to your house; Admitted and found proved

b. pursued an improper emotional relationship with Patient A. To be determined

3. Your actions as described at paragraph 2 were sexually motivated. To be determined

4. Between November 2016 and April 2017, whilst she remained your patient, you engaged in a sexual relationship with Patient A. To be determined

5. On 19 February 2017 you assisted in Patient A's surgery despite Patient A's request that you not be involved. To be determined

6. In or around March 2017 you examined Patient A and removed her stitches and:

a. the examination was inappropriate as it took place at your home address; To be determined

b. you failed to record this consultation in Patient A's medical records. To be determined

7. On 10 March 2021, you submitted an appraisal form ('the Appraisal Form') to King's College Hospital NHS Foundation Trust in which you failed to declare that your registration was subject to an open GMC investigation. Admitted and found proved

8. You knew that:

a. your registration was subject to an open GMC investigation at the time you submitted the Appraisal Form; To be determined

b. you were required to declare that your registration was subject to an open GMC investigation within the Appraisal Form. To be determined

9. Your omission as described a paragraph 7 was dishonest by reason of paragraphs 8.a and 8.b. To be determined

10. In the Appraisal Form you implied that a complaint made against you had been resolved when you stated '[Dr B] helped to resolve this'.
Admitted and found proved

11. The comment included at paragraph 10 above:

a. was untrue; and
Admitted and found proved

b. you knew it to be untrue.
To be determined

12. Your action as described at paragraph 10 was dishonest by reason of paragraphs 11.a and 11.b.
To be determined

The Admitted Facts

18. When the case first started, Mr Steer was not present, but before the end of the GMC case he attended the hearing and remained for the rest of this stage. The Allegation was put to him, and he admitted some paragraphs as outlined above.

The Facts to be Determined

19. In light of the above, the Tribunal had to make a determination in relation to the remaining paragraphs of the Allegation, as set out above.

Witness Evidence

20. The Tribunal received:

- 7 statements from Patient A, dated 22 January 2021, 9 June 2022, 16 August 2022, 22 December 2022, 8 February 2022, 17 April 2023 and 28 June 2023;
- A statement from Dr E, Responsible Officer at King's College hospital, dated 10 January 2022;
- 2 statements from Ms D, Investigation Adviser at the GMC, dated 18 March 2022 and 1 November 2022.

- A statement from Mr Steer dated 10 March 2023.

21. All the witnesses gave evidence at the hearing, as did Mr Steer.

Expert Witness Evidence

22. The Tribunal received an expert report from Mr B, Consultant Obstetrician and Gynaecologist, dated 24 June 2021 and 5 supplementary reports dated 5 October 2021, 18 July 2022, 23 August 2022, 7 July 2023 and 30 January 2025. The Tribunal also received a report from Professor C, dated 9 March 2023 and a joint report from Mr B and Professor C dated 16 March 2023.

23. Mr B also gave evidence at the hearing.

Documentary Evidence

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

- Patient A's complaint letter to the GMC dated 3 June 2020;
- Mr Steer's letter dated 17 December 2015 to Patient A's GP following his consultation with Patient A on 16 December 2015;
- Operation notes dated 29 December 2015 and 5 October 2016;
- Medical records of Patient A;
- Photographs of Mr Steer with Patient A;
- Birthday card sent from Mr Steer to Patient A;
- WhatsApp messages between Mr Steer and Patient A;
- Email correspondence between Mr Steer and Dr E – various dates;
- Two undated documents from Mr Steer prepared in response to the allegations;
- A document from Mr Steer entitled *'Reflections on the CP complaint'*, received on 12 July 2022;
- NICE Guidelines entitled *'Laparoscopic Uterine Nerve Ablation (LUNA) for Chronic Pelvic Pain, interventional procedures guidance, published 30 October 2007'*;
- Royal College of Obstetricians and Gynaecologists Guidance (RCOG) on obtaining consent for a hysteroscopy which is dated December 2008. (Consent Advice number 2.);
- Other Guidance produced by Mr Steer during the course of the hearing.

The Tribunal's Approach

25. The LQC gave legal advice and reminded the Tribunal that the GMC brings this Allegation and the burden of proving each paragraph is on the GMC; there is no

burden on the doctor to prove anything.

26. There is one standard of proof in civil and regulatory cases and that is of the balance of probabilities, i.e., whether it is more likely than not that the events occurred as alleged.

27. The Tribunal should have regard to the whole of the evidence and form its own judgement about the witnesses, and which evidence is credible and reliable, and which is not.

28. Tribunals should not exclusively rely on a witness' demeanour when giving evidence *(Dutta v GMC [2020] EWHC 1974 (Admin)*. A confident witness may give unreliable evidence. A nervous and hesitant witness may give reliable evidence. In cases where the substance of the evidence is 'one person's word against another' because of the nature of the case - alleging sexual motivated behaviour it may be reasonable for a Tribunal to take into account aspects of a witness's demeanour, but a tribunal should consider the consistency over time and under cross-examination, in assessing truthfulness. Tribunals should note any gaps and discrepancies and give reasons for their evaluation and conclusions in relation to them, *Joseph v GMC [2022] EWHC 3345 (Admin).* The Tribunal is advised to navigate the evidence by looking at contemporaneous documentary material as a starting point although actual corroboration of a witness account is not legally necessary.

29. In this case, Patient A was granted anonymity, and the Tribunal was aware that Special Counsel had been instructed by the MPTS to cross-examine Patient A should it have been needed. The Tribunal is directed that these measures do not mean that Patient A's evidence carries any more weight, nor should it reflect on or prejudice Mr Steer. They are simply measures to assist Patient A to give her evidence.

30. Some of the witness statements in this case have been admitted into evidence, yet not formally agreed by the GMC. Those witnesses did not give their evidence at the Tribunal, and so it must decide what weight, if any to give to their written evidence.

31. Any documentary evidence and exhibits should be considered by the Tribunal and it should give them such weight as it feels appropriate.

32. The Tribunal has heard from an expert who has given evidence relating to clinical issues that are outside the Tribunal's general knowledge. The Tribunal should consider whether the expert has sufficient expertise to express the opinions that he has on the topics that he has. This is a matter of weight for the Tribunal to assess. A tribunal does not have to accept expert opinion, but if it decides not to accept it, then it must set out our reasons why that is the case. This is established in the case of *Cohen v GMC (2008) EWHC 581 (admin).*

33. The Tribunal must judge the doctor's evidence by precisely the same fair standards as apply to any other evidence in the case. Counsel for the GMC has confirmed that a

good character direction can be given. Therefore, the Tribunal will have in mind that the doctor is a man of good character. This means that he had no criminal convictions or cautions, or adverse misconduct related regulatory findings. The Tribunal is reminded that the doctor is:

(a) more likely to be telling the truth in his evidence, and
(b) might be less likely to have behaved in a way as set out in the Allegation.

34. However, good character of itself does not amount to a defence and its significance should not be over inflated. The primary focus should be on the evidence related to the wrongdoing.

35. If the Tribunal prefers the witness's version of events over that of the doctor, then it should make clear why the doctor's evidence has been rejected.

36. There is an allegation in this case that the matters set out in paragraph 2, if proved, were sexually motivated. For an act to be sexually motived it has to firstly be sexual – which is an act which is by its nature sexual, or because of its nature it may be sexual and because of its circumstances or purpose it is sexual.

37. Secondly, the Tribunal should have regard to the definition of the term 'motive' which is defined in the case of *Basson v GMC [2018] EWHC 505* as:

'A sexual motive means that the conduct was done either in pursuit of sexual gratification, or in pursuit of a future sexual relationship'.

38. The Tribunal must be satisfied on the balance of probabilities that sexual motivation can be inferred from all the circumstances. The circumstances of the acts alleged, and the Doctor's explanation should all be considered.

39. There is an allegation in this case that the matters set out in paragraph 12, if proved, amounted to dishonesty. The Tribunal is directed therefore to apply the test as set out by Lord Hughes at paragraph 74 of *Ivey v Genting Casinos [2017] UKSC 67* which states:

'When dishonesty is in question, the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the factfinder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest'

40. Therefore, the Tribunal must ascertain (subjectively) the actual state of Mr Steer's knowledge or genuinely held belief as to the facts at the material time. If this is established, the Tribunal would have to decide whether this was dishonest by (objective) standards of ordinary decent people. If this is not established, then dishonesty would not be proved.

41. Each paragraph of the Allegation should be treated separately. Some of the paragraphs refer to conduct having taken place for example 'between' dates. The Tribunal does not need to decide that the conduct occurred at a specific time, but rather that the conduct occurred within the time span mentioned.

42. Unless otherwise directed in this advice, the Tribunal should give the words in the paragraphs their ordinary meaning, as would be described in an English dictionary.

The Tribunal's Analysis of the Evidence and Findings

43. The Tribunal accepted the LQC's advice and considered all the evidence that it had received, both written and oral.

44. The Tribunal was mindful that Mr Steer was not present when three of the GMC witnesses gave their evidence, because it had refused his application for an adjournment, and had proceeded to hear the case in his absence. The witnesses who gave evidence in Mr Steer's absence were Patient A, Ms D and Dr E. The Tribunal was aware that it was incumbent on it to ensure that the case was conducted fairly when Mr Steer was absent. The witnesses confirmed that the statements they made to the GMC were true and accurate and the Tribunal put questions to them that reflected the written responses from Mr Steer and the explanations that he put forward in them.

45. Having heard from the GMC witnesses, the Tribunal found their evidence credible and reliable, and in part corroborated by contemporaneous documentary material. The Tribunal also took into account Mr Steer's good character when considering the differing accounts given in this case.

46. The Tribunal took into account Mr B's curriculum vitae and accepted that Mr B was an experienced consultant and expert in obstetrics and gynaecology. It gave weight to and relied on the reports he produced, and the clear oral evidence that he gave. Mr Steer was present when Mr B gave his evidence, and so was able to cross examine him about the clinical aspects of this case. The Tribunal took into account the report from Professor C but as the Professor did not give oral evidence, the Tribunal decided that his written report carried less weight than the reports from the GMC expert, Mr B.

47. The Tribunal read and considered the written evidence of Ms F and Ms J but did not have the benefit of hearing oral evidence from these witnesses at the Tribunal. It took their witness statements into account, but did not give them as much weight as they

might have done if they had given evidence.

Paragraphs 1(a)(i), 1(a)(ii)1, and 1(a)(ii)2 of the Allegation

48. The Tribunal decided to consider paragraph 1(a)(i), 1(a)(ii)1, and 1(a)(ii)2 together, because they all relate to an operation that took place on 19 December 2015. The Tribunal considered whether Mr Steer performed a hysteroscopy on that date when it was not clinically indicated, and a LUNA as a course of action over and above treatment of endometriosis, which was again not clinically indicated.

49. The Tribunal firstly considered the evidence from Patient A. In her statement dated 22 January 2021, she stated that she first met Mr Steer in his clinic on 16 December 2017, after he had been recommended to her. She explained:

> *'At my consultation with Dr Steer, he reviewed some photographs from my recent Laparoscopy. On review of the photographs, Mr Steer explained that he would need to operate on me in order to remove the adhesions in place from my recent Laparoscopy. Mr Steer went on to outline some of the available options to me. I agreed to have another operation in order for him to remove the adhesions.'*

50. The Tribunal then considered the medical records relating to this operation. It noted the clinical letter that Mr Steer sent to Patient A's GP dated 17 December 2015, before the procedure had taken place. It states that Patient A had presented with pain and a recurrence of endometriosis, that she was given the option of medication, but that she preferred to have another operation. It states:

> *'I gave her the option of increasing her progestergens over and above the Cerazette to high dose Provera or Zoladex with add back HRT, or another operation. She would prefer to have another operation. I have booked her for Blackheath and I will attempt to obliterate any recurrent endometriosis, divide the utero sacral ligaments to prevent her from having pain, divide any pelvic adhesions and then continue on Cerazette long term in order to prevent recurrence of this intransigent endometriosis'.*

51. The Tribunal took into account the Operation Note (the Note) dated 19 December 2015, which has a comment written on it -'*cautery to utero sacral ligaments.'* Then, in the post operative clinical letter sent to the GP dated 29 December 2015, Mr Steer wrote that *'both utero sacral ligaments were cut close to the cervix in order to try and reduce the amount of pain that she is in'*.

52. From the explanation given by Mr B in his evidence, the Tribunal understood that Mr Steer's stated intention to divide the utero sacral ligaments, the comment in the Note that he had cauterised them, and the post operative letter stating that he cut them, were conflicting and confusing but that they would all have necessitated a LUNA procedure. They would all have resulted in the destruction of sacral utero ligaments,

which could have caused a prolapse of the womb.

53. Mr B confirmed in his first report dated 24 June 2021, that according to the medical records, Mr Steer had conducted both a hysteroscopy and a LUNA on Patient A on 19 December 2015. He explained in his evidence that the hysteroscopy conducted was a diagnostic procedure where a camera was inserted into the Patient A's uterus through the vagina. The LUNA was an operative laparoscopy when Mr Steer cauterised or cut the utero sacral ligaments.

54. Mr B concluded in his report that there was no clinical indication for a hysteroscopy, and stated:

> *'There was no clinical indication for a hysteroscopy and this was an unnecessary intervention with potential risks. The inclusion of a hysteroscopy in an adolescent with endometriosis was below the expected standard.'*

55. Mr B also decided that it was not appropriate to carry out a LUNA procedure and stated:

> *'Laparoscopic uterine nerve ablation (LUNA) was appraised by NICE in October 2007 and the clear conclusion reached was that the evidence of this laparoscopic procedure for chronic pain suggested that it was not efficacious and the procedure should therefore not be used. I would expect Mr Steer to have been aware of this Guidance and to have taken appropriate notice of the advice.'*

56. The Tribunal noted the NICE Guidance, which is entitled *'Laparoscopic Uterine Nerve Ablation (LUNA) for Chronic Pelvic Pain, interventional procedures guidance*, *published 30 October 2007',* which states in its headline that LUNA *'is not efficacious and therefore should not be used.'*

57. Mr B expressed concern in his report dated 24 June 2021 that Mr Steer had specifically planned a LUNA procedure knowingly contrary to the NICE Guidance. He said in his oral evidence that the NICE Guidance was *'very clear'* that LUNA should not be carried out, and by 2015 it was an outdated procedure having been advised against in 2007. Previous to 2007, Mr B explained that LUNA was the *'last ditch attempt'* for a woman before resorting to a hysterectomy. Regarding the NICE Guidance, Mr B states:

> *'…I would expect Mr Steer to have been aware of this Guidance and to have taken appropriate notice of the advice. Potential adverse effects included vascular, bowel or ureteric injury, bleeding, the need for conversion to open surgery and prolapse. The performance of a laparoscopic uterine nerve ablation on 19 December 2015 was seriously below the expected standard. The evidence indicates that Mr Steer specifically planned and proceeded with uterine nerve ablation as a separate course of action over and above*

treatment of any endometriosis and this was seriously below the expected standard'.

58. Mr B noted from the medical records that the operation appeared to have been uncomplicated, meaning that neither procedure was indicated. Only minor endometriosis was identified and treated. He stated that:

> *'Such minor deposits would have been expected to have been responsive to a 3-6 month course of LHRH analogue treatment.'*

59. The Tribunal noted that Mr B made his supplemental report dated 18 July 2021, after he had received some earlier medical records relating to Patient A that predate the operation on 19 December 2015. After having considered these, Mr B did not resile from his original conclusion that the procedures were not clinically indicated and was of the view that because there had been a previous hysteroscopy in October 2015, a further hysteroscopy was certainly not indicated. He stated:

> *'…There was less of a reason for Mr Steer to proceed with a hysteroscopy on 19 December 2015 given that this had been previously performed by Miss [M] when she had taken a biopsy and fitted an intrauterine system in April 2015'.*

60. The Tribunal considered the joint report from Mr B and Professor C, dated 16 March 2023. In it, both experts agreed that performing a hysteroscopy was not clinically indicated for a woman who had presented solely with endometriosis. They both agreed that a LUNA was an outdated procedure and was also not clinically indicated.

61. In his oral evidence, Mr B did not demur from the opinion that he gave in his reports. He stated that the threshold for surgery in this case was too low, and that Patient A was placed on an accelerated surgery pathway. He said a LUNA was not appropriate for a patient of such a young age, who has not had children yet. He said that because an operation is invasive, then there is always a risk of injury to other organs, or of scarring. In answer to questions from the Tribunal he said that, in his view, the consultant who had treated Patient A before this operation, should also have more actively promoted medical treatment before surgery. Because this had not been done, it was all the more imperative that Mr Steer promoted medication or injections rather than go for a third procedure.

62. When considering the WhatsApp messages, the Tribunal noted an exchange between Mr Steer and Patient A which gave an insight into Mr Steer's attitude toward Guidelines. Mr Steer mentions that he 'tries to help' even if what he is doing is outside Guidelines. The messages are as follows:

> *'10/03/2016 01:03:07: [Patient A]: They made a big point of telling me that 😢 it's not in my head but that's why I try and keep busy, like tonight it's getting bad again, I just need to learn to control it better 😌*

10/03/2016, 01:04:16: Chris S: I'm so sorry is that your GP ?

10/03/2016, 01:04:39: [Patient A]: No pruh obviously 10/03/2016,

01:07:15: Chris S: Yes but don't take any notice of what they say about that they are just driven by guidelines and hate someone like me who try's to help even if falls outside their guidelines Have you been back to Pruh ?'

63. The Tribunal went on to consider the explanation that Mr Steer had given about this operation in his written statement dated 10 March 2023, which he reiterated in his oral evidence. He asserted that a hysteroscopy was clinically indicated and that a LUNA procedure was carried out to treat the persistent uterine pain being caused by endometriosis. He stated that he began to think that the colleague who had operated before may have missed something, because the extent of pain that Patient A was experiencing was rare. He said that he discussed this matter with Patient A and the options available to her. He mentioned that she could take medication but explained that it could take several months to see a reduction of the pain, an option which was therefore declined by Patient A.

64. Mr Steer explained in his statement that he is aware of the NICE Guidelines but nevertheless decided to carry out the procedures in order to exclude uterine adhesions as contributing to her pain and any uterine anatomical anomaly which could possibly explain the XXX. He said that Patient A had XXX. He said that he informed Patient A that a hysteroscopic examination would exclude an anatomical abnormality in the uterus as a possible cause for her XXX and enable the treatment of any uterine adhesions or exclude their presence.

65. The Tribunal considered the two undated documents written by Mr Steer. Mr Steer referred to the NICE guidelines and associated case studies and stated that they show a success rate in the reduction of pain when a LUNA procedure is carried out in cases of endometriosis. He said in his evidence that he was able to mitigate some of the risk by using a specific entry technique, and that the modern methods now meant that the risks were minimal. Mr Steer referred to a specific case study of a patient of his, who had written a book about his care. He states that the operations with this other patient that had taken place under the NICE Guidelines had not worked, but that this case study showed that:

'It is possible to provide individualized evidence-based care over and above nice guidelines when they have failed. Such as the approach I had with [Patient A]'

66. Mr Steer states in his undated document that treating all patients who are in pain in the same way is not effective, and that the operation on Patient A was *'individualized'* for her, and that she woke up pain free and was able to return to work.

67. Mr B's supplemental report dated 27 January 2025 considered Mr Steer's explanations that are outlined above. He said that Mr Steer states that Patient A was in the small percentage of patients where treatments consistent with the NICE

Guidelines had not worked. However, he said that Mr Steer failed to address the young age of Patient A, the other options available, and the rapid turnover of laparoscopies that she had had.

68. Mr B, when asked about individualised care at the hearing, said that this was proper, but that in Patient A's case, a course of injections for 6 months would have been more appropriate. He said that injections should have been more actively promoted, because they are safe, effective, and can be used long term.

69. Mr B also pointed out that the NICE Guidance about LUNA was very clear, and that there is often a post- operative placebo effect which is transient, which could explain Patient A's ability to return to work.

70. The Tribunal took into account the views of both experts in the joint expert report. They noted that Mr Steer had said that he conducted the hysteroscopy because of the potential for anatomical abnormalities relating to XXX. Professor C give the opinion that this would have been reasonable, had it not been for the hysteroscopy and insertion of a Mirena coil that had taken place in April 2015 and its removal by way of a laparoscopy in October 2015, both of which postdate XXX and predate the 19 December 2015 operation.

71. Mr B did not accept Mr Steer's interpretation of the NICE case studies, stating that the controlled trials that were carried out showed no significant differences in pain relief for women with pelvic pain, when LUNA was carried out. In his oral evidence, Mr B confirmed that he did not accept Mr Steer's suggestion that the case studies that suggest that LUNA is an effective way to manage pain relief for patients with endometriosis would mean that a LUNA was appropriate. He pointed the Tribunal to the publications that he had referenced in his last report and stated that none of those gave the LUNA procedure a *'green light'.* He said that six randomised controlled trials had taken place, which was high quality evidence, and Mr Steer should not therefore have resorted to his own anecdotal evidence and experience in the light of this detailed data. In response to Mr Steer's opinion of the full NICE Guidelines, he stated:

> *'Such a threshold for treating endometriosis by LUNA was not highlighted as an exclusion when the NICE Guidelines were later published, and nor was LUNA widely adopted in the first place. Even prior to the NICE Guidelines this was only rarely performed. It is also noteworthy that* [Patient A] *did not have extensive endometriosis. Dr Steer's microdissection of the literature only serves to confuse and distract from the headline advice given and the conclusions reached by NICE which remain as published and resulted in the effective abandonment of LUNA after 2007.'*

72. Mr B states in the supplemental report dated 30 January 2025, that if Mr Steer were concerned about deep deposits of endometriosis, then imaging in the form of an MR scan should have taken place rather than proceed with an operation straight away. He

stated that, in any event, the Operation Note indicates that in Patient A's case there was minor endometriosis only, and a subsequent MR scan showed no deep deposits, so the procedure was unwarranted. He said that Mr Steer's explanation that he was looking for adhesions was *'completely irrelevant'* because they were not present anyway, and there was no strong reason to suspect them.

73. In his evidence to the Tribunal, and in the questions that he put to Mr B, Mr Steer stated that there were conflicting guidelines, and those relating to fertility issues and heavy menstrual bleeding were different to the NICE Guidance. He asserted that Patient A was trying to get pregnant at the time she came to see him. He explained that she had a boyfriend, XXX. In answer to his questions, Mr B said that there was no evidence in the medical records that Patient A was trying to get pregnant. He said that his advice in these circumstances would be patient specific, but it could be that they are advised to conceive, or have injections for 6 months, or have non-hormonal treatment. It depends on the woman, their desire and timing.

74. In short, Mr B did not alter his view that the hysteroscopy and LUNA were not clinically indicated. In his oral evidence, he stated that, although he understood Mr Steer's argument, he did not accept it and said there was *'absolutely no need'* for the hysteroscopy, and it was inappropriate to have conducted the LUNA. He said that although he would *'never say never'* he was not aware of any LUNA cases since 2007. He said Guidelines are in place that are expensive to produce, because of the research and trials involved. They are put in place for good reason, and if ever they are contravened, that would have to be carefully justified and documented.

75. In the report from Professor C, the Tribunal noted, that although Professor C said that the hysteroscopy was not clinically indicated, he considered Mr Steer's explanation about Patient A's past history, and the XXX, and stated that:

> *'although most clinicians would have done an ultrasound scan to exclude uterine anomalies, in the context of performing a laparoscopy, a hysteroscopy would have been reasonable for this purpose and therefore not fall below the expected standard for a reasonably competent consultant gynaecologist.'*

76. Professor C accepted in his report that conducting a LUNA on Patient A was contrary to the NICE Guidelines, but he said that there was conflicting evidence in the Guidelines as to its effectiveness, because the Guidance is aimed at cases where the women being considered for the operation have little or no endometriosis.

77. The Tribunal considered all the above evidence and Mr Steer's explanation and noted firstly that there was no dispute that Mr Steer had in fact conducted a hysteroscopy and LUNA operation on 19 December 2025.

78. The Tribunal reflected that Mr B had given oral evidence at the hearing. He confirmed that the reports he had produced accurately reflected his opinions which he did not change when cross examined. His evidence was also consistent with the advice in the

NICE Guidelines. In contrast, Professor C did not give evidence and therefore could not be cross examined by the GMC or asked questions by the Tribunal. The Tribunal only had his written report, which it gave less weight to than the expert reports from Mr B. The Tribunal noted that Professor C partially corroborated Mr B in any event.

79. The Tribunal therefore accepted and preferred the evidence of Mr B to that of Mr Steer. In so doing, it decided to accept Mr B's expert opinion that both the hysteroscopy and the LUNA procedures were not clinically indicated. Patient A, who was XXX at the time had presented with recurring endometriosis and the Tribunal accepted Mr B's view that a course of treatment should have been actively promoted as the better option for her, rather than proceeding straight to surgery.

80. The Tribunal determined that conducting the LUNA procedure was contrary to the NICE Guidelines, something which Mr Steer accepted. It noted Mr Steer's explanation about the NICE Guidelines and the case studies, but accepted from Mr B that those studies did not demonstrate that there were significant differences in pain relief when a LUNA was carried out for women with pelvic pain, and did not give a practitioner the 'go ahead' to conduct a LUNA in cases involving endometriosis. It also noted that Guidance of this nature took into account not just efficacy, but the risks posed and cost effectiveness too. The Tribunal determined that if a procedure contrary to any Guidelines were to take place, then it would have to be heavily justified, and should have been the subject of a multi-disciplinary meeting before it was carried out.

81. The Tribunal accepted from Mr B that if Mr Steer had concerns about other anatomical abnormalities or deep deposits of endometriosis, then a MR scan should have been conducted first, and also that he should not have had such concerns in any event, because there had been a hysteroscopy carried out since the XXX and before the operation on 19 December 2015, which would have discovered them.

82. The Tribunal also considered Mr Steer's assertion in his oral evidence that Patient A was trying to get pregnant at the period of time when the operation took place. He said in evidence that the fertility guidance conflicts with the NICE Guidance, and he also wanted to try to ascertain during the operation whether the womb was normal. The Tribunal did not accept this explanation. There were no contemporaneous medical records that suggest that Patient A wanted a baby at that time, and Mr Steer had not raised this issue in his written statements. Patient A was taking Cerazette at the time and had a few months earlier had a Mirena coil inserted. Although Cerazette and the insertion of a coil can assist in the treatment of endometriosis, the Tribunal noted that they also act as a contraceptive, something that Patient A would have known. Also, the WhatsApp messages sent between Mr Steer and Patient A after the operation do not support the assertion that Mr Steer thought that Patient A had a boyfriend at this time. For example, there is a message exchange approximately a month later, on 25 January 2016 which reads:

> *'19:08:03: Chris S: I thought you had a nice boyfriend already just convince him that you would have delightful babies together lol 😀 25/01/2016,*

19:08:53[Patient A] 😘 : Ok Thankyou and nice? Boyfriend? No, I'm fine Thankyou 😊 '

83. Despite Mr Steer's assertion in evidence that he *'did what was best for the patient'* the Tribunal decided, on the balance of probabilities, that Mr Steer had inappropriately operated on Patient A, by performing a hysteroscopy when there was no clinical indication, and a LUNA as a course of action over and above treatment of any endometriosis, when it was not clinically indicated.

84. Accordingly, the Tribunal found paragraphs 1(a)(i), 1(a)(ii)1, and 1(a)(ii)2 of the Allegation proved.

Paragraph 1(b) of the Allegation

85. The Tribunal considered whether Mr Steer failed to obtain informed consent from Patient A for the procedure as outlined in paragraphs 1(a)(i) and (ii).

86. The Tribunal firstly considered the evidence from Patient A. In her statement dated 9 June 2022, she stated that she had so many procedures that she could not specifically recollect the consent process relating to the operation on 19 December 2015, but she said:

> *'From my recollection, Mr Steer always followed the correct process in relation to consent.'*

87. The Tribunal considered the Consent Form in the medical records. It appeared to have been completed by Mr Steer and signed by both Mr Steer and Patient A. There were no intended benefits listed, and the only risk was *'bleeding'*. Mr B, in his supplemental report dated 5 October 2021, explained that:

> *'…The form referred to treatment of endometriosis, operative laparoscopy, hysteroscopy and uterine nerve ablation. The entry referring to intended benefits was left blank. The heading "Seriously or frequently occurring risks" contained one word "Bleeding". References to blood transfusion or other procedures were also left blank'*

88. Mr B in his supplemental report dated 23 August 2021 listed the risks of this type of operation. He stated that the Consent Form was incomplete and below the expected standard of a competent practitioner given the nature of the proposed surgery which included inappropriate interventions with distinct risks.

89. Mr B also referred to the Royal College of Obstetricians and Gynaecologists Guidance (RCOG) on obtaining consent for a hysteroscopy which is dated December 2008. (Consent Advice number 2.) The Tribunal noted that the Guidance sets out the serious and frequently occurring risks in an operation of this nature which should be addressed in a consent form. Mr B s said that these risks should have been addressed

with Patient A, even though she had undergone previous laparoscopies. In his oral evidence he said that a consultant should never assume that a patient has knowledge even if they work in an obstetric clinic. In his 23 August 2021 report, he stated:

> *'Reported complications have been few but there have been case reports describing a total of five women developing uterine prolapse after having laparoscopic uterine nerve ablation'.*

90. In the joint report between Mr B and Professor C dated 16 March 2023, the Tribunal noted that they both agreed that Mr Steer had failed to obtain appropriate informed written consent from Patient A for the operation on 15 December 2015.

91. In his supplemental report dated 7 July 2023, Mr B explained that in his view, Patient A was, because of her age, more vulnerable and susceptible to any advice and recommendations given by Mr Steer and would therefore be expected to be more agreeable to the suggested interventions in the absence of an adequate explanation of the risks and benefits, and possible alternative approaches. He said that '*Dr Steer's actions set the scene for an unacceptable surgical trajectory for Patient A without medical alternatives.'*

92. In his supplemental report dated 30 January 2025, the Tribunal noted that Mr B was of the view that the fact that a decision was taken to operate just two days of seeing Patient A (with the consultation ostensibly occurring on the same day that the referral was made) meant that she did not '*have enough breathing space to consider her options'* and that her admission could be described as '*unnecessarily precipitate'.*

93. In his oral evidence to the Tribunal, Mr B stated that the consent forms for the procedures that had taken place on Patient A in April and October 2015, by a different consultant were much more detailed. They explained the associated risks of intervention, surgery and further surgery, with a list of potential complications too.

94. The Tribunal took into account the written statement from Mr Steer. In it he states:

> *'Head of charge 1(b) is admitted in that I accept that the written consent form that was completed was not adequately completed.'*

95. Mr Steer goes on to further explain that he accepts that the Consent Form does not show that fully informed consent was obtained, and he accepts that he did not fully explain the risks for the laparoscopy and that these should have included:

> *'a. infection,*
> *b. thrombosis*
> *c. damage to internal organs such as bowel, bladder ureters and blood vessels blood transfusion in case on intraabdominal bleeding*
> *e. the need for laparotomy in case of damage to intrabdominal viscera.'*

96. Mr Steer said in his statement that, in his experience such complications do not occur, but he accepts that Patient A should have been warned about them.

97. In his oral evidence to the Tribunal, Mr Steer said, *'I dispute that I failed to give appropriate consent.'* In his questions to Mr B he said that Patient A was a XXX in the clinic and knew what the operations were about anyway. In his evidence on oath, Mr Steer said that *'it was very easy to frighten a patient.'* He explained that consent includes giving the patient standard information and leaflets which set out all the risks and benefits and he stated that Patient A had a preoperative assessment, and they would have been given to her at that time. He said that when a patient gets to surgery it should be a time when all they need to do is ask any questions that they have.

98. The Tribunal asked Mr Steer why he had admitted that he had not given informed consent in his written statement. He explained that he accepted that he had not applied 'the gold standard' set out in the RCOG Guidelines. He explained that at that time he would inform a patient of the complications that might occur in an operation that he was conducting personally, using his experience and knowledge from the operations he had done in the past. He accepted that in future he would set out the risks as per the Guidance.

99. The Tribunal decided that there was sufficient evidence that Mr Steer had not obtained informed consent from Patient A. Although it noted that Patient A felt that Mr Steer usually followed the correct process, it was concerned that the Consent Form was clearly inadequate and did not set out the intended benefits, nor detail the risks as advised in the RCOG Guidelines. It took the view that the lack of informed consent was exacerbated by Patient A's age, the fact that the procedures were not clinically indicated, and that they carried risk.

100. The Tribunal accepted Mr B's opinion that the consent in this case was not fully informed. The Tribunal shared his concern that Patient A was young, vulnerable, and given very little time to consider the other options available. In Mr B's view, this resulted in Patient A being placed on an unnecessary surgical trajectory. The Tribunal noted that Professor C agreed with Mr B.

101. It also saw that Mr Steer accepted in his written statement that the written consent form was not adequately filled out, and that he did not fully explain the risks to Patient A. In his oral evidence he further accepted that he had not applied the 'gold standard,' when filling out the Consent Form.

102. When considering all the evidence, the Tribunal decided on the balance of probabilities, that Mr Steer did not obtain fully informed consent from Patient A.

103. Accordingly, the Tribunal found paragraph 1(b) of the Allegation proved.

Paragraphs 2(a)((ii) and 2(a)(iii) of the Allegation

104. The Tribunal considered whether, between February 2016 and September 2016, while Patient A remained his patient, Mr Steer engaged in conversations by way of WhatsApp messages, commenting on how attractive he found her and inviting her to meet him for drinks.

105. When Patient A first made her complaint to the GMC on 3 June 2020, the Tribunal noted that she described the messages that she started to receive from Mr Steer from February 2016 onwards. She said:

'Around February of 2016 I was working with Mr Steer at Chelsfield Park Hospital he started to text me. First of all, it was just to see how I was as I had been taken to A&E. Within a couple of weeks these messages had started to get suggestive. By April 2016 he'd offered to do a private scan for me free of charge when I said I didn't need a scan he stated that I should come and meet him for a drink or cocktails. The same night he texted me and said meet me outside Chelsfield Hospital and I'll go back to mine with you. Other texts included him mentioning how attractive I was and how he is attracted to me.'

106. The Tribunal considered Patient A's first statement, dated 22 January 2021, in which she described the background to the relationship. She said that she first met Mr Steer when she was referred to him in December 2015 as a patient. As a XXX, she had worked with him on one or two occasions but did not know him very well. She then stated that from February 2016 she began working him on a weekly basis, and their interactions increased. She explained that:

> *'Between February and September 2016, Mr Steer started to send me text messages on a regular, weekly basis. The tone of the text messages seemed flirtatious. Mr Steer would write about how attractive he found me and regularly invite me out for drinks. At the start, I responded to his messages but not in the same context as him. Mr Steer explained that we were just friends, and his text messages constituted workplace banter.'*

107. Mr Steer did not address this aspect of the Allegation in his written statement, but in one of his undated responses he alleged that the WhatsApp messages were edited by Patient A to show a type of relationship that was not real. He states:

> *'I do not recognise the sexual connotations in the WhatsApp messages which have been forwarded to the GMC, on examining them, I am certain that they were edited.'*

108. Mr Steer reiterated this view in his oral evidence. The Tribunal therefore considered the evidence about the WhatsApp messages carefully.

109. The Tribunal noted that Patient A explained in her first statement that she had kept some of the WhatsApp messages from Mr Steer, and she attached a schedule of them to her statement. The Tribunal noted that some of these messages were screen shots.

Patient A said that they were not complete, because on 26 December 2016, she exported all the messages to her email and deleted them on her phone. She said she had limited storage space on her phone, but did not want to delete the chat history with Mr Steer. Patient A then explained that she deleted further messages in February 2017, when Mr Steer asked her to do, because he was conducting the operation on her and he did not want the staff to be aware of their relationship, and then again in April 2017, when the relationship ended.

110. The Tribunal read the other statements that Patient A made that related to her deletion and storage of the WhatsApp messages. Through the GMC, and with the assistance of Microsoft she explained that she had retrieved more messages from her archives and produced those in a second schedule with her statement dated 28 June 2023.

111. Patient A gave evidence in a clear and credible manner when asked about the messages. In response to questions from the Tribunal, she stated that she had not altered them in any way and she confirmed that they were accurate. She said that the second schedule was a more complete account, because when she sent the first schedule to the GMC, she only forwarded those that she thought were relevant to her complaint.

112. Mr Steer explained in his undated response, and again in his oral evidence that there are two ways to back up WhatsApp messages, one which would ensure that they remain encrypted and cannot be altered, and one which is transferred as a Word processor document and can be easily edited. He said Patient A had used the method where the messages could be edited. He also explained that, from his own research, he had ascertained that the emojis in the messages were only created by WhatsApp in 2018 and so could not have been used in the time frame of February 2016 to September 2016. He summarised saying:

> *'This would suggest that A had formulated a plan in the three years, during which I was working with her in the clinic after these events to edit the WhatsApp messages over a period of three years before complaining.'*

113. The Tribunal noted, that by admitting paragraph 2(a)(i) and 2(a)(iv), Mr Steer had accepted that there were WhatsApp messages sent between him and Patient A. In his oral evidence, in response to specific messages or chats being put to him, he accepted, for example, the innocuous messages about Patient A's health, but claimed that Patient A had inserted or edited those of a sexual or flirtatious nature. He claimed that Patient A had changed the time on some messages, e.g. messages sent after midnight. He also said that Patient A had added emojis and kisses to some messages.

114. The Tribunal did not have the benefit of Mr Steer's own WhatsApp message data, and did not receive any expert IT evidence. It noted that in his oral evidence, Mr Steer suggested that the GMC had a full and accurate record of the WhatsApp messages

that it had failed to disclose. This was not accepted by the GMC.

115. Taking all the above into account, the Tribunal did not accept Mr Steer's assertion that the messages had been edited in the way he described. The Tribunal decided that Mr Steer's explanations about Patient A adding or editing messages to an ongoing chat, altering the time on some messages, and adding kisses and emojis on others were not credible. The Tribunal found it unlikely that Patient A had fabricated and edited such voluminous and detailed messages and perpetrated such an elaborate falsehood over a 3 year period as alleged by Mr Steer. The messages, especially those that were screen shots, would have needed detailed and painstaking editing. It did not accept that the GMC was complicit in this falsehood, by withholding the accurate account, because collusion between Patient A and the GMC seemed unlikely. The Tribunal also took into account the fact that the second schedule, produced with the advice of Microsoft, was consistent in tone and content with the first schedule that Patient A had provided.

116. The Tribunal therefore relied on the second schedule that Patient A had produced. It noted that there were many hundreds of messages between Patient A and Mr Steer. They started the day after the hysteroscopy and LUNA procedures on 19 December 2015. They covered and included the time period between February 2016 and September 2016. The last message on the schedule is dated 26 December 2016. During this period of time, Patient A was still a patient of Mr Steer. He carried out a laparoscopy procedure, for example, in September 2016, and she had a follow up appointment with him in October 2016.

117. The Tribunal considered the allegation in paragraph 2(a)(ii) firstly, namely whether, in the WhatsApp messages, Mr Steer had commented on how attractive he found Patient A. It noted again that Patient A said in her first statement to the GMC:

> *'…Other texts included him mentioning how attractive I was and how he is attracted to me.'*

118. The Tribunal found numerous comments from Mr Steer in the messages to this effect and some examples and passages are included below:

> *'25/02/2016, 00:01:28: Chris S: You and your friends are young and very attractive and would find me too old and ugly ?? Xxx*
> *25/02/2016, 00:02:07: [Patient A]: Course not xxx'*
> *…*
>
> *'25/02/2016, 00:30:36: Chris S: Wow we have been chatting for over 2 hours If someone saw this they would say that I found you extremely attractive ? Xxx'*
>
> *…*
>
> *'25/02/2016, 00:59:24: Chris S: Trouble is I am sober otherwise would say far too much*
> *Goodnight sleep and dream well xxx*

25/02/2016, 01:00:04: [Patient A]: As if I mind what you say, just banter right? As if you mean any of it xxx
25/02/2016, 01:02:01: Chris S: That's the trouble your a very attractive young woman and I'm an older man so no chance xxxx'
…

'09/03/2016, 22:52:00: Chris S: Lol you are a smart intelligent attractive young woman who has everything going for her ? 😈*'*
…

'10/03/2016, 01:12:24: [Patient A]: Don't think there's much helping me lol! I'm a nightmare
10/03/2016, 01:13:51: Chris S: Hardly your a very attractive intelligent young woman more a mans dream not nightmare 😊
10/03/2016, 01:14:22: [Patient A]: Dream??? Definitely not 😂
10/03/2016, 01:15:27: Chris: 😍*I'm certain of it I'll dream about you all the time* 😁*'*
…

'14/03/2016, 22:13:24: Chris S: No because you have a rounded personality of intelligence maturity and attractive'
…

'27/04/2016, 23:28:36: Chris S: No I wouldn't do that
You must know your very attractive to men though 😈*'*

…

'27/04/2016, 23:30:49: [Patient A]: What else then???? I'm nothing
27/04/2016, 23:31:26: Chris S: Everything about you is attractive not least your intelligence xx'

119. The Tribunal next considered the allegation in paragraph 2(a)(iv) namely whether, in the WhatsApp messages, Mr Steer had invited Patient for drinks. It noted again that Patient A said in her first statement to the GMC:

'… he stated that I should come and meet him for a drink or cocktails.'

120. The Tribunal found some messages from Mr Steer inviting Patient A for drinks. Some examples and passages are included below:

'24/02/2016, 23:03:09: Chris S: That's high carbs what about alcohol instead ? X
24/02/2016, 23:03:59: [Patient A]: Got to love alcohol 🍷🍸 *cocktails? X*
24/02/2016, 23:04:28: Chris S: Which ones ? X
24/02/2016, 23:05:46: [Patient A]: Sex on the beach is def the best 🍹*X*
24/02/2016, 23:07:19: Chris S: Wow who gave it that name surely a very little risky? X

24/02/2016, 23:08:05: [Patient A]: Risky? Course not X
24/02/2016, 23:08:58: Chris S: Not risky cocktail or risky sex on beach ? Xx
24/02/2016, 23:10:31: [Patient A]: Both 😂xx
24/02/2016, 23:12:46: Chris S: It's a shame I wasn't 20 again then perhaps I could find out lol 😡xx
24/02/2016, 23:13:11: [Patient A]: Sure not being 20 doesn't matter xx
24/02/2016, 23:13:50: Chris S: But I'm 25 that must be too old for that xx'
…
'01/03/2016, 00:21:07: Chris S: Because if you came round here and we had a few drinks then what would happen ? Xx
01/03/2016, 00:21:56: [Patient A]: Oh how would I get home??? Couldn't drive after a few drinks 🤔😅 what do you mean what would happen??? Xx
01/03/2016, 00:24:56: Chris S: Because things could progress you are a very attractive young woman xx'
…

'01/03/2016, 23:12:34: Chris S: Who could I ask I have so many here Champagne red wine whisky far too much for me on my own ? 😂
01/03/2016, 23:13:31: [Patient A]: I'm sure you could think of someone 😂
01/03/2016, 23:14:23: Chris S: Who do you suggest would eat chocolates and drink with me xx
01/03/2016, 23:15:20: [Patient A]: Someone that would be on that match making list and able to drink cocktails with you xx
01/03/2016, 23:16:24: Chris S: That sounds an exciting list
That would be a very special person lol xx
01/03/2016, 23:16:48: [Patient A]: Very exciting and maybe not special but lucky ??Xx

…

'10/03/2016, 01:43:44: [Patient A]: When you find them obviously X
10/03/2016, 01:44:15: Chris S: The woman or the cocktails xx
10/03/2016, 01:44:52: [Patient A]: Woman, cocktails is the easy bit X
10/03/2016, 01:46:14: Chris S: Perhaps I already found her now just need the easy bit of the cocktails ? Xx
10/03/2016, 01:47:27: [Patient A]: Maybe and yep just that part then you're good to go, maybe she'll give you that kick up the bum I said you needed tonight and you'll be on time??? 🤦X
10/03/2016, 01:48:36: Chris S: How should I know which cocktails she will especially like? X
10/03/2016, 01:48:53: [Patient A]: Either ask or just guess x

10/03/2016, 01:50:03: Chris S: Asking sounds more reliable? Xx

10/03/2016, 01:50:47: [Patient A]: Maybe X

10/03/2016, 01:51:17: Chris S: How will she drive home after drinking cocktails? Xx

10/03/2016, 01:52:02: [Patient A]: She may have to run home X
10/03/2016, 01:54:00: Chris S: But that might not be safe perhaps X
10/03/2016, 01:54:35: [Patient A]: I don't know then, maybe only the one then could drive? X
10/03/2016, 01:56:38: Chris S: That would be possible
Come to the Sloane on Friday after you finished and let's work it out ? Xx
10/03/2016, 01:57:04: [Patient A]: You won't finish till late though? X

10/03/2016, 01:57:58: Chris S: What time do you finish at CHELSFIELD? X

10/03/2016, 01:58:06: [Patient A]: 9 I think X
10/03/2016, 01:59:08: Chris S: Then I'll wait for you in outpatients
Do you know where the outpatients is at the Sloane ? X
10/03/2016, 02:00:17: [Patient A]: Isn't that too risky for you though? X
10/03/2016, 02:01:36: Chris S: Why there won't be anybody else there and I'll scan you professionally as a patient first xx
10/03/2016, 02:02:09: [Patient A]: The scan isn't needed X
10/03/2016, 02:03:00: Chris S: Ok the cocktails only then? Xx
10/03/2016, 02:03:44: [Patient A]: Just don't want to get you into trouble if seen?x
10/03/2016, 02:04:42: Chris S: Then could meet somewhere private? X
10/03/2016, 02:05:31: [Patient A]: Let me know when you're done on Friday and we'll talk about it then X'

121. The Tribunal considered Mr Steer's evidence in relation to these allegations. In his undated response he denied making the comments about Patient A being attractive. He said:

> *'It is disputed that I commented how attractive I found A. The segment has been edited'.*

122. Mr Steer, in his undated statement also denied asking Patient A her to meet him for drinks. He said:

> '[Patient A] *worked with me in my clinic for about a year before I had XXX. At no time during that year did I meet her outside work, invite her out for a meal or a drink or suggest any social contact the only time we could've met outside of work, would be the staff Christmas party although as it was 8 years ago I'm unsure if she was there.'*
>
> *'Although* [Patient A] *worked with me for a year before I had XXX, she didn't meet me outside of work and was not invited to do so, until I returned from XXX and she helped me.'*

123. The Tribunal took into account the oral evidence that Mr Steer gave to the Tribunal. He denied sending any of the inappropriate messages to Patient A. He again said that the messages had been edited, and that he did not recognise the banter. He said, *'she most probably kept a diary and for some reason, monetary of whatever, she decided to set me up.'* When asked if he had told Patient A that she was an '*attractive young*

woman' and asked her to join him for cocktails, he said *'why would I say this? It looks like grooming. I wouldn't do that.'* He said that he would not message so late at night, because he would be in bed asleep at that time.

124. The Tribunal relied on the WhatsApp schedule when coming to its decision and noted the messages, examples of which are quoted above. The schedule corroborated Patient A's accounts that she gave both in her email of complaint in June 2020, and her subsequent written statement to the GMC. The Tribunal did not accept Mr Steer's explanations about the messages and found his account not credible.

125. Accordingly, the Tribunal found paragraphs 2(a)(ii) and 2(a)(iii) of the Allegation proved.

Paragraph 2(b) of the Allegation

126. The Tribunal considered whether, between February 2016, and September 2016, while Patient A remained his patient, Mr Steer pursued an improper emotional relationship with her.

127. The Tribunal again noted that Patient A was a patient of Mr Steer's during this period.

128. The Tribunal again considered the complaint that Patient A made in June 2020 and the first statement that she made to the GMC. She described that after the December 2019 operation, and while they were working together, Mr Steer stated to text her, and within a couple of weeks the messages *'started to become suggestive.'*

129. In her oral evidence, Patient A said that, at first, she did not respond in the same context as Mr Steer, and that she did not understand, because he was her doctor, and they were just friends. In answer to questions from the Tribunal, Patient A explained that, in the workplace, Mr Steer was very friendly with all the XXX and was *'laughing and joking'* with them. She said that she ignored it at first, but the messages to her started to increase, and Mr Steer became more *'flirty'* toward her, and he was not asking the other XXX out for drinks.

130. The Tribunal then considered the WhatsApp messages on the schedule, which gave it an insight into the developing relationship between Patient A and Mr Steer. It noted that there were hundreds of messages sent between the two of them during the period February 2016, and September 2016.

131. The Tribunal noted that the first entry was on 20 December 2015, when Patient A made contact with Mr Steer, thanking him and the anaesthetist for their help the previous day. The messages continued from there and at first were of a friendly and sociable nature. On New Year's Eve, the messages started to change in tone. For example, Mr Steer said:

> *'30/12/2015, 21:17:29: Chris S: I'm sure they will you'll still be able to wear a bikini in the summer and no scars will be visible x*
>
> ...

30/12/2015, 23:05:02: *Chris S: Many young women of your age part exchange boy friends for someone better'*

132. The Tribunal noted that over a period of time, the messages demonstrated a developing relationship between Patent A and Mr Steer. There were exchanges about Patient A's health but also chats about whether Patient A had a boyfriend. The messages became more personal and more flirtatious over time.

133. The Tribunal took into account its findings in relation to paragraph 2(a)(ii) and 2(a)(iii), which demonstrate the amount of times that Mr Steer complimented Patient A and offered to meet up with her for drinks outside of work.

134. The Tribunal noted that Mr Steer admitted paragraph 2(a)(i), and accepted therefore that he had offered, by WhatsApp message, to do a private scan free of charge for Patient A. Mr Steer had also admitted paragraph 2(a)(iv), and accepted therefore that on one or more occasions, he had asked Patient A to go to his house.

135. The Tribunal considered the WhatsApp messages to see the context in which the comments alleged in paragraph 2(a)(i) were made. It noted the following passages:

'10/03/2016, 00:45:54: Chris S: Sorry it's all a bit intense for late at night
Your still welcome to come across to the Sloane on Friday evening for s scan if you like ?
10/03/2016, 00:46:47: [Patient A]: Aren't all our conversations a bit intense to you?
10/03/2016, 00:47:41: Chris S: I do laugh sometimes as well it just doesn't seem often enough'
...
'10/03/2016, 00:56:29: Chris S: Ok but you can still come to Sloane on Friday if you like for a scan you said to remind you ?
10/03/2016, 00:56:52: [Patient A]: I just think a scan will be a waste of time, nothing ever shows up □
10/03/2016, 00:58:08: Chris S: Perhaps I'll be able to help you this time ?
10/03/2016, 00:58:21: [Patient A]: Help?
10/03/2016, 00:59:08: Chris S: To get rid of pain perhaps i do really care how you feel?'
...
'10/03/2016, 01:56:38: Chris S: That would be possible
Come to the Sloane on Friday after you finished and let's work it out? Xx
10/03/2016, 01:57:04: [Patient A]: You won't finish till late though? X
10/03/2016, 01:57:58: Chris S: What time do you finish at CHELSFIELD? X
10/03/2016, 01:58:07: [Patient A]: 9 I think X
10/03/2016, 01:59:08: Chris S: Then I'll wait for you in outpatients
Do you know where the outpatients is at the Sloane? X
10/03/2016, 02:00:18: [Patient A]: Isn't that too risky for you though? X
10/03/2016, 02:01:36: Chris S: Why there won't be anybody else there and I'll scan you professionally as a patient first xx
10/03/2016, 02:02:10: [Patient A]: The scan isn't needed X

10/03/2016, 02:03:00: Chris S: Ok the cocktails only then? Xx
10/03/2016, 02:03:44: [Patient A]: Just don't want to get you into trouble if seen? x
10/03/2016, 02:04:42: Chris S: Then could meet somewhere private? X
10/03/2016, 02:05:31: [Patient A]: Let me know when you're done on Friday and we'll talk about it then X
10/03/2016, 02:06:14: Chris S: Ok goodnight till then xx'
…
'14/03/2016, 21:07:57: Chris S: Come and see me fill your bladder and I'll do a tummy scan with a chaperone and I'll get you well again if I can
14/03/2016, 21:13:37: [Patient A]: I can't get authorisation tonight though??? A scan isn't likely to show anything though is it?
14/03/2016, 21:15:37: Chris S: Don't bother with authorisation I don't charge colleagues and friends anyway
14/03/2016, 21:17:18: [Patient A]: But I feel like I'm just taking the piss 😢
14/03/2016, 21:18:06: Chris S: Of course your not you'll always be at least a Friend'

136. The Tribunal then considered the WhatsApp messages to see the context in which the comments alleged in paragraph 2(a)(iv) were made. It noted the following passages:

'01/03/2016, 23:12:34: Chris S: Who could I ask I have so many here Champagne red wine whisky far too much for me on my own ? 😂
01/03/2016, 23:13:31: [Patient A]: I'm sure you could think of someone 😂
…

'01/03/2016, 00:21:07: Chris S: Because if you came round here and we had a few drinks then what would happen ? Xx
01/03/2016, 00:21:56: [Patient A]: Oh how would I get home??? Couldn't drive after a few drinks 😕🙄 *what do you mean what would happen??? Xx*
01/03/2016, 00:24:56: Chris S: Because things could progress you are a very attractive young woman xx'
…
'27/04/2016, 23:48:33: Chris S: Why are you going to move in with me 🎆☺😘
27/04/2016, 23:48:57: [Patient A]: Can do, I'm very useful round the house 👍
27/04/2016, 23:49:25: Chris S: Ok come round tonight see if you like it xxxx
27/04/2016, 23:49:56: [Patient A]: Ok will do, see if it's arranged to my OCD x'

137. The Tribunal took into account the statements from two nurse colleagues, Ms F and Ms J, while noting that they had not given evidence at the Tribunal hearing. Neither of them said that Mr Steer nor Patient A informed them of a relationship.

Ms F said:

'When I did see Mr Steer and [Patient A] *interact at the hospital, Mr Steer acted professionally and had a very kind and friendly demeanour. I did notice that* [Patient A] *seemed slightly more interested whenever speaking with Mr Steer. On multiple occasions, I saw* [Patient A] *speaking to Mr Steer outside of his consultation room and I could see her leaning on the door. …In my opinion, her mannerisms were slightly flirtatious but there was no physical interaction between Mr Steer and* [Patient A] *such as touching that I saw. I thought at the time that* [Patient A]*'s behaviour was due to her age and lack of maturity.'*

Ms J said:

'I noticed that when Dr Steer called regarding consultations, [Patient A] *was eager and jumped up to assist most of the time. I remember her frequently being in Dr Steer's consultation room. I cannot recall any particular interactions between Dr Steer and* [Patient A].

138. The Tribunal then considered Mr Steer's evidence in relation to this allegation. He denied sending any inappropriate messages by WhatsApp, stating in his oral evidence that Patient A had '*decided to set me up'.* Mr Steer said that the messages that were sent were of a friendly nature, and that he was giving Patient A continuing help and advice with her condition.

139. Mr Steer said in his oral evidence that he was '*WhatsApping innocently.'* The Tribunal took into account the explanations he gave both in his undated response, and his oral evidence. In relation to the offer of a free scan, Mr Steer said that people of his generation often performed a free consultation or investigation for colleagues and friends. He said that he treated colleagues and nurses, and did not invoice them if they did not have private health insurance, especially if they were lower paid employees. He said that he had a small portable scan, which can be used anywhere.

140. However, the Tribunal looked at the context in which these offers were made. They were made informally, without consultation, and on WhatsApp, juxtaposed with flirtatious comments, and suggestions about meeting for drinks.

141. The Tribunal also noted that Mr Steer said that the only reason that Patient A came to his house was because he suffered a XXX injury XXX. He said that he had informed the hospital that he could not drive after his XXX injury, and Patient A offered to help XXX.

142. However, the Tribunal noted that the arrangements to go round to Mr Steer's house were made in a suggestive and flirtatious manner and did not relate to Patient A giving him XXX and assistance. According to the XXX that Mr Steer provided from XXX, Mr Steer's injury in XXX took place on 25 October 2016, after this period of time in any event.

143. In conclusion, the Tribunal decided to prefer the account of Patient A instead of that given by Mr Steer, and it accepted her description of what was happening in the workplace. It determined that her account was not undermined by the evidence in the written statements from Ms F and Ms J and that it was corroborated by the many WhatsApp messages sent between her and Mr Steer.

144. The Tribunal did not accept the assertions made by Mr Steer that some of the messages were false or edited, nor that others were sent as friends or to help Patient A with her health issues. The Tribunal looked at the messages as a whole, and decided that within their context, they demonstrated that Mr Steer was pursuing an emotional relationship with Patient A.

145. The Tribunal was concerned that Patient A was a patient of Mr Steer's between February 2016 and September 2016, while this relationship was being pursued. She had gynaecological issues that Mr Steer was treating. He was a senior consultant, and she a junior XXX. The Tribunal therefore decided that the developing relationship was improper.

146. Accordingly, the Tribunal found paragraph 2(b) of the Allegation proved.

Paragraph 3 of the Allegation

147. The Tribunal considered whether the actions described in paragraph 2 of the Allegation were sexually motivated. In doing so, it considered the description of the developing relationship given by Patient A which is quoted in detail above. In her complaint in June 2020, Patient A said that from February 2015, Mr Steer started to message her, and that *'Within a couple of weeks these messages had started to get suggestive'.* In her witness statement dated 22 January 2021, Patient A said, *'The tone of the text messages seemed flirtatious'*.

148. The Tribunal again considered the WhatsApp messages. They were many in number. Mr Steer often complimented Patient A on her physical appearance and asked her round to his home and also to meet up for drinks. The messages were often sent late at night and were flirtatious and suggestive. Mr Steer made comments such as '*things could progress'*, '*could meet somewhere private? X,'* and '*you'll always be at least a Friend'*.

149. The Tribunal had not accepted Mr Steer's assertions that some of the messages were false or edited, nor that others were sent because they were friends or to help Patient A with her health issues. It had decided that Mr Steer, during this period of time, was pursuing an improper emotional relationship.

150. When deciding whether Mr Steer's conduct was sexually motivated, the Tribunal considered the case of *Basson.* It considered Patient A's account, and the content of the WhatsApp messages. It was satisfied on the balance of probabilities that Mr Steer was pursuing a future sexual relationship with Patient A.

151. Accordingly, the Tribunal found paragraph 3 of the Allegation proved.

Paragraph 4 of the Allegation

152. The Tribunal considered whether Mr Steer then engaged in a sexual relationship with Patient A, between November 2016, and April 2017, when she was still his patient.

153. The Tribunal firstly considered Patient A's complaint dated 3 June 2020. She said that on 4 November 2016, Mr Steer gave her his home address, and details for the security gate code, still asking her round for drinks. She then said *'This soon turned into a sexual relationship, even though he'd operated on me twice. This continued for several months.'*

154. Patient A explained that in January 2017, Mr Steer attended her XXX. She said that Mr Steer came to her family home on a couple of occasions, and that they also went shopping, and to restaurants and the cinema.

155. The Tribunal then considered the statement that Patient A made to the GMC on 22 January 2021. She confirmed that she started a sexual relationship with Mr Steer in November 2016. She said:

'I first saw Dr Steer socially on 5 November 2016, on bonfire night. I went to his house to meet him, and we spent the night together. Throughout November 2016, our relationship developed into a sexual relationship. Due to the nature of our relationship, I no longer felt that a doctor–patient relationship was suitable.'

156. Patient A said in her statement that Mr Steer had helped her buy the alcohol and was *'very drunk'* at her XXX, and that this behaviour started rumours at the hospital.

157. Patient A confirmed that she '*broke up'* with Mr Steer in April 2017.

158. The Tribunal considered the documentary evidence in this case. It noted some photographs that Patient A had produced of her and Mr Steer together on her XXX, and a XXX card from him saying '*XXX, love chris, xxxx.'* Patient A stated that her parents were aware of the relationship, and XXX.

159. The Tribunal considered the WhatsApp messages that were sent between Patient A and Mr Steer from November 2016 onwards. It noted that they stopped on 26 December 2016, and so they only partially covered the period of time when the sexual relationship was alleged. They were many in number, and intimate in nature.

160. On 4 November 2016, The Tribunal noted that a number of messages were exchanged, with both Patient A and Mr Steer suggesting that she go round to his house for drinks and dinner. Mr Steer gave Patient A the security code for his gate. It is clear that, at that time, Mr Steer had returned from XXX and had sustained a XXX injury.

161. The Tribunal noted a chat on 6 November 2016, that demonstrated that Patient A had been round to Mr Steer's house:

> *'06/11/2016, 08:32:05: Chris S: Thanks for wonderful evening drive safely xx*
> *06/11/2016, 09:32:26: Chris S: Hi are you ok did I do something wrong ?*
> *06/11/2016, 09:33:02: Chris S: Did you get home ok xx*
> *06/11/2016, 09:35:46: [Patient A]: Thankyou to you too! Sorry nothing wrong…'*

06/11/2016, 09:45:26: Chris S: Just worried that I got you to drink too much
06/11/2016, 09:50:46: [Patient A]: No it's fine 😊xx
06/11/2016, 10:01:11: Chris S: I hope your not in pain 😍xx
06/11/2016, 10:03:40: [Patient A]: I'm used to it now 😂xx
06/11/2016, 10:05:40: Chris S: I didn't mean to hurt you I'm sorry xx
06/11/2016, 10:49:53: [Patient A]: It wasn't you, don't worry 😊xx

162. The Tribunal noted a chat on 7 November 2016 which demonstrated that the relationship had become more intimate:

'07/11/2016, 21:05:33: Chris S: Do you think it would be bad if people at work found out ?
07/11/2016, 21:06:19: [Patient A]: There's nothing to find out though?
07/11/2016, 21:07:13: Chris S: Only that we spend time together ?
07/11/2016, 21:08:10: [Patient A]: One night so far? Which in all seriousness "companions" don't do!! So that's why I asked what you want so I know where this is going.....
07/11/2016, 21:09:52: Chris S: Boy friend girl friend for as long as you want ?
07/11/2016, 21:10:15: [Patient A]: For as long as I want?
07/11/2016, 21:10:40: Chris S: Yes you'll get fed up with me at some stage
07/11/2016, 21:11:22: [Patient A]: Is that what you are worried about?
07/11/2016, 21:11:47: Chris S: No only being realistic
07/11/2016, 21:12:59: [Patient A]: Not very realistic but ok then 😂
07/11/2016, 21:13:31: Chris S: What would you like ?
07/11/2016, 21:15:11: [Patient A]: I said I wasn't sure, honesty and respect first, no calling me round in weekends so a repeat of Saturday can happen when you feel like it though!'

163. The Tribunal noted that, by 17 November 2016, Mr Steer and Patient A were discussing their relationship and its future:

' 10/11/2016, 23:14:18: Chris S: If you want us to be together long term it's fine if you want for a few years so that I can help you [XXX] that's fine
I'll put up with it
There are many more advantages for me to be with you than for you to be with me
10/11/2016, 23:17:39: [Patient A]: You need to be honest with me because at the moment it looks purely sexual!!!
10/11/2016, 23:19:50: Chris S: Ok let's be honest that part didn't go well because I'm too old and not any good at it
What about if I wanted to be with a young attractive woman to look after me as I grew old
How does that leave you.'

164. The Tribunal noted a chat at the beginning of December 2016, which demonstrated the ongoing relationship:

> *'01/12/2016, 22:19:18: Chris S: I'd be delighted to see you however you are Are you hungry ?xx*
> *01/12/2016, 22:19:59: [Patient A]: Not particularly x*
> *01/12/2016, 22:20:29: Chris S: Ok can just have a drink then ? Xx* 😘
> *01/12/2016, 22:21:35: [Patient A]: Then a cuddle? I'm in a real cuddly mood* 😘😍*x*
> *01/12/2016, 22:22:03: Chris S: Of course lots of cuddles xx* 🙏
> *01/12/2016, 22:23:01: [Patient A]: I'm going to leave now then, but I'll knock on the door* 😂🐒*xx*
> *01/12/2016, 22:23:23: Chris S: Ok great see you soon xx'*

165. The Tribunal noted a chat on 7 December 2016, where Mr Steer suggested that he and Patient A live together:

> *'07/12/2016, 20:53:02: Chris S: The reason I looked at that [XXX] house was because I thought there might be some chance we could live there together but now something is wrong but not sure what ? X'*

166. The Tribunal took into account Mr Steer's response to this Allegation. He did not address the relationship in his written statement dated 3 March 2023. In his undated response, Mr Steer denied that he had a sexual relationship with Patient A. He stated:

> *'It is false that between November 2016, and April 2017, I engaged in a sexual relationship with* [Patient A]. *She only ever met me out of work when I was [XXX] such that I would have considered a sexual act to be the last thing on my mind as it would undoubtedly have caused [XXX] and I would've been unable to perform such a procedure. Of note is that the WhatsApp messages come to an end when she no longer was assisting me in December 2016, and the extension to April 2017 is fictitious without any presented evidence.'*

167. Mr Steer, in his oral evidence to the Tribunal again denied that there had been a sexual relationship between him and Patient A. He accepted that he had attended the XXX, and had slept at the house, but said that so had Patient A's XXX. He pointed out that there were other photographs with him with other colleagues at XXX, which the Tribunal noted.

168. Mr Steer said that some of the WhatsApp messages were false, and he would only accept those that were innocuous. When some of the passages set out above were put to him, he denied having sent them. He pointed out that the messages corresponded only to the time that he was XXX.

169. Mr Steer said that Patient A only came round to his house to XXX, and to drive him and to and from work while he was injured, XXX. He said that was why she had some house keys and knew the security code for the gate. He also said that she was paid to

do this. He said he never otherwise saw her socially out of work, and that would have been *'completely ridiculous.'*

170. Mr Steer also explained that he could not have had sexual intercourse with Patient A, because of XXX.

171. The Tribunal asked Patient A questions about XXX when she gave her evidence, and whether it prevented sexual activity. She said that they had vaginal sex, and Mr Steer was able to '*continue the act'* with XXX.

172. The Tribunal noted that Mr Steer accepted in his evidence that he had caused a '*grey area'* and that he would not do anything like this again and conceded that he may have got too close to Patient A. He said it was '*unwise'* in retrospect, and that matters had become open to interpretation. He said that he had been '*foolish and stupid'* and that this was '*a honeytrap.'* In response to questions from the Tribunal, Mr Steer said that he accepted that the GMC expected sharp demarcation lines between a doctor and patient, and that it was imperative that this was maintained.

173. When reaching its conclusion, the Tribunal preferred Patient A's account over the account given by Mr Steer. She gave credible and consistent accounts, and her evidence was corroborated by the WhatsApp messages, which gave the Tribunal a detailed insight into the relationship. The Tribunal decided that Mr Steer's explanations were not credible and were undermined by the WhatsApp messages. The Tribunal was satisfied therefore, on the balance of probabilities, that Mr Steer engaged in a sexual relationship with Patient A, and that she was his patient at that time.

174. Accordingly, the Tribunal found paragraph 4 of the Allegation proved.

Paragraph 5 of the Allegation

175. The Tribunal considered whether Mr Steer assisted in Patient A's surgery on 19 February 2017, despite Patient A's request that he not be involved.

176. The Tribunal noted that, according to both the medical records and the recollection of Patient A, she was admitted into hospital on 18 February 2017, and it was decided that she would undergo a laparoscopy. However, due to an urgent surgery involving another patient, this was delayed until the following day, 19 February 2017.

177. The Tribunal considered the initial complaint that Patient A made on 30 June 2020, which is the earliest account that it had. Patient A stated that when she felt ill in February 2017, Mr Steer advised her to go to Accident and Emergency at the Princess Royal Hospital (PRUH). They were in a relationship at this time. This was on a Saturday and Mr Steer was on call on the Sunday, and she said that he called through to the team so that she would be admitted straight away and advised them to keep her there until Sunday. On the Sunday, Patient A said that she told Mr Steer that she did not want him to operate on her, and that he promised her three times that he would

not do so. He said that he would text about it, because he did not want the ward staff to see him keep coming into her room. When she went down to theatre she explained:

'mr steer was in theatre but for the third time he promised me he would not be doing the surgery. When I was back on the ward and awake, I found out mr steer had actually performed the entire surgery. I discharged myself from hospital at that point as I was not happy.'

178. In Patient A's statement dated 22 January 2021, she described again what happened in the lead up to the surgery in February 2017:

'Mr Steer came to see me on 19 February 2017, before my surgery. I told Mr Steer that I did not want him to perform the procedure because we were in a sexual relationship and I was worried it might get him in trouble. Mr Steer told me not to worry and that he would arrange for someone else to do the procedure. Mr Steer told me to delete any and all messages I had received from him, so no one could find out about our relationship. Mr Steer also told me not to call him whilst I was in PRUH. I was then taken to theatre to have my surgery.
After the surgery, Mr Steer told me that he was present in theatre, but that he did not conduct the procedure.'

179. Patient A then stated, that she saw her medical records, and noticed that Mr Steer had performed the procedure and she stated:

'I was upset when I found out that Mr Steer conducted the procedure despite my clear instructions and decided to discharge myself. Around ten days later, I visited Mr Steer at his home and apologised for how I reacted after the procedure.'

180. The Tribunal heard oral evidence from Patient A. She told it that she had believed Mr Steer when he told her that he would only be involved in the surgery in a supervisory nature, and that when she saw the *'record of the operation'* he then admitted to her that he had performed it. She was sure that she spoke to him after the surgery and that he admitted this to her.

181. The Tribunal noted the medical records in this case and saw that the '*record of the operation'* has the surgery as having been performed by '*Dr [N]/Mr Steer'* and had Mr Steer noted down as *'assistant 1.'*

182. In Mr B's first report, the Tribunal noted that, by looking at the *record of the operation,* and considering Patient's A's account, Mr B ascertained that, in his view, Mr Steer was involved in the surgery on 19 February 2017. He stated:

'Mr Steer was involved in the surgery and was named as the Responsible Consultant but does not appear to have been the primary surgeon, being described as assisting

(and effectively supervising Dr [N]).'

183. In his supplemental report dated 23 August 2022, Mr B quoted from the medical records that he had received:

'The Surgical Safety Checklist referred to Mr Steer being the operating surgeon'
'Mr Steer made an entry at 10.00 hours on 20 February 2017 when the surgery was said to have been explained and that there had a been a recurrence of the endometriosis. The next entry appears to refer to treatment with Helica. She was to be discharged home the next day with a follow up after two months.'
'Dr H Senior House Officer wrote at 15.00 hours that Patient A had undergone surgery with Mr Steer the previous day and that she had been reviewed by him that morning. the plan was for her to be reviewed the following day and for her to have pain relief with no acute concerns.'
…
'Ms P wrote at 18.30 hours how she had been in the room with Mr Steer and had then been asked by Patient A to leave the room. She added that Mr Steer had not documented his conversation in the medical records.'

184. In his oral evidence, Mr B explained that a procedure of this nature *'needed a second pair of hands'* so it is likely that two doctors would have been involved. If there had been another assistant, he or she would have been named rather than Mr Steer, and if the *record of operation* were incorrect Mr Steer should have corrected it.

185. The Tribunal considered Mr Steer's written statement and noted that he denied this allegation. He explained that Patient A was admitted on 18 February 2017, and that she asked him not to perform the surgery because they were friends. He said that he was the only consultant available because it was a weekend. He described the position as:

'At our hospital one consultant was on call to cover both Obstetrics and Gynaecology without a second for backup. I asked the Senior Registrar, who was covering both obstetrics and gynaecology to conduct the surgery, leaving me to cover the labour ward. I explained to Patient A that as there were no other consultants available, the oncall Senior Registrar would perform the procedure, and that I would be available to assist in the event of a complication. I explained that the alternative would be to delay the procedure until another consultant was available. Patient A did not wish to delay the procedure and confirmed that she was content with this arrangement.'

186. Mr Steer stated that the Senior Registrar carried out the surgery and said that even though he was put down on the surgery form as 'assistant 1' he was there only in a supervisory role, was not in scrubs, and was covering the labour ward. He said that it was a Senior House Officer who assisted the Senior Registrar.

187. The Tribunal considered the two undated documents written by Mr Steer. In the first, Mr Steer stated that when he was asked by Patient A not to perform the surgery, he

offered her alternatives, such as finding another consultant- which he could not do-, asking the Senior Registrar to perform the surgery, or taking her off the emergency list. He said that Patient A did not want to wait and so the surgery proceeded. He said that he covered the labour ward, but:

'I did put my head round the door to make sure it was going smoothly and I saw from the screen that the laparoscopy was progressing normally. I then left Ihe senior Registrar to finish off and went back to Labour Ward.'

188. Mr Steer stated in this undated response that he did not see Patient A after the surgery because she discharged herself. He explained:

'I went down to the gynaecology ward after the operation to explain the findings and the fact that the senior registrar had done the operation who was on the ward round with me, but unfortunately [Patient A] *had taken her own discharge, and I was unable to see her.'*

189. The Tribunal listened carefully to the account that Mr Steer gave in his oral evidence, which in some ways was inconsistent with his earlier accounts. He said that Patient A did not want him involved in the operation because she wanted to try with someone else, because what he had done previously had not worked. This is at odds with his written statement where he said that it was because she and he were friends. (The Tribunal noted that Patient A had not said that she had any such concerns when he undertook a procedure on her in September 2016, even though they were friends at that point.) Having said in his undated response that he had not seen Patient A after the surgery, Mr Steer said in evidence that he went to see her with Dr N, but that she was sleepy. He said that he could not recall going to see her on his own, nor the nurse being asked to leave, even though that is what the medical record states. Mr Steer said that he did not know why the '*record of operation'* was filled out how it was, because all he did was put his head round into theatre. He accepted that he reassured Patient A that he would not be involved in the operation.

190. Mr B's opinion, in his report dated 23 August 2020, is that the extent to which Patient A's situation warranted urgent surgical intervention was questionable, and that if a consultant's presence was deemed necessary, then the surgery should have been deferred until such back up was available. In his oral evidence, he confirmed that he was of the view that in the unusual circumstance that a patient asks for a particular consultant not to be involved, then, even if it were just in a supervisory role, arrangements should have been made to accommodate this. He said that Mr Steer could have contacted a colleague to take over, or Patient A could have been put on the surgery list for the following day.

191. When coming to its conclusion, the Tribunal relied on the contemporaneous documentation that it had received. It noted that there were various medical records that demonstrated Mr Steer's involvement in this operation, not least the '*record of operation'* that was made at the time. It clearly states that Dr N and Mr Steer

performed the surgery, with Mr Steer being marked down as the assistant.

192. The Tribunal accepted the evidence given by Patient A, which was clear and was reiterated in her oral evidence. Her account that she spoke to Mr Steer after the surgery on his own is not accepted by him but is corroborated by the nursing note that states that at 18:30 (ie after the surgery), the nurse was asked to leave the room while Mr Steer and Patient A spoke. The Tribunal decided therefore that, on the balance of probabilities, a conversation took place between Mr Steer and Patient A after the surgery. It accepted Patient A's account that Mr Steer admitted involvement in the surgery and accepted that this is why she discharged herself from the hospital.

193. The Tribunal also took into account the expert opinion given by Mr B, that his reading of the medical notes led him to conclude that Mr Steer was involved in the surgery, was named as the consultant, but was not the primary surgeon.

194. The Tribunal considered the explanation from Mr Steer, but preferred to rely on the documentary evidence and the account given by Patient A. Her account is corroborated by the *'record of operation'* which the Tribunal considered for itself and also accepted Mr B's interpretation of it.

195. The Tribunal decided therefore on the balance of probabilities that Mr Steer assisted in the surgery on 19 February 2017, despite Patient A's request that he did not.

196. Accordingly, the Tribunal found paragraph 5 of the Allegation proved.

Paragraphs 6(a) and 6(b) of the Allegation

197. The Tribunal considered these two paragraphs together because they relate to the same alleged incident in March 2017. The Tribunal considered whether, in or around March 2017, Mr Steer examined Patient A at his home address and removed her stitches, which was inappropriate, and whether he failed to record these consultations in Patient A's medical records.

198. The Tribunal firstly considered the complaint that Patient A had made, dated 3 June 2020. In it, Patient A describes what happened after the surgery had taken place on 19 February 2017. She said that Mr Steer started to text her again and continued to ask her round to his house. She stated:

'One day I eventually went round to find out why he'd done the operation. He actually took my stitches out while I laid on his bed, with a pair of scissors.'

199. The Tribunal also noted Patient A's account of this incident in her statement dated 22 January 2021. She said that she went round to Mr Steer's home and apologised for how she had reacted after the surgery. She said:

'Mr Steer accepted my apology and then asked if he could take out the stitches I had from the procedure. The stitches were dissolvable, but the medical staff told me that they did not know how long they would take to fully dissolve. Chelsfield had told me that I could not go back to work with stitches. I therefore allowed Mr Steer to take out my stitches at his home, so I could go back to work sooner.'

200. The Tribunal noted that Mr Steer, in his written statement, denied this allegation. He said:

'I did not examine Patient A at my home address and remove her stitches. The stitches she had been given were dissolvable and therefore would not have required removal. I would not have had the surgical stitch cutter at home that I would have required for the removal of stitches.'

201. The Tribunal also considered the two undated documents written by Mr Steer and noted that he claimed that this allegation is false, again stating that he did not have the equipment at home, and that the stitches could have been removed easily in their workplace.

202. In his oral evidence, Mr Steer said that this incident '*didn't happen,'* and that it would have been *'absolutely stupid'.* He said again that he did not have any medical equipment at his home and added that it was not registered with the Care Quality Commission as a premises where medical procedures could be carried out. He said that he would not have used nonsterile scissors because Patient A's wound could have got infected. He said Patient A could easily have asked a nurse at the clinic to take her stitches out.

203. The Tribunal asked Patient A about Mr Steer's assertion that this allegation was false when she gave oral evidence at the hearing. She explained that the stitches were dissolvable, and if they had been left, they would not need to have been taken out, but that she was not allowed to work with them in. This is why Mr Steer offered to take them out. She recalled that Mr Steer did not have special medical equipment at his home, but that he used tweezers from his bathroom to pull the stitches, and scissors to cut them.

204. The Tribunal noted that Mr B's opinion was that the response to this allegation from Mr Steer '*does not stand up to scrutiny.'* Mr Steer said that he did not remove the stitches at his home address, because he did not have the medical equipment to do so, and because the stitches were dissolvable anyway. However, Mr B stated that there was no need for medical equipment to be used to remove stitches stating that *'a small pair of ordinary scissors would have sufficed'.* Mr B also stated that patients often ask for dissolvable stitches to be removed if they are taking longer to dissolve than expected or if they are causing discomfort or irritation. Mr B pointed out that Mr Steer had actually removed Patient A's dissolvable stitches after the operation in December 2015 and a second laparoscopy in September 2016.

205. Mr B's view was that if the Tribunal found that Mr Steer examined and removed Patient' A's stitches at his home address that would be inappropriate in any event given his alleged relationship with Patient A at the time and stated that Mr Steer should have made a record of any such consultation in his records.

206. The Tribunal noted that there was no medical record of Mr Steer removing the stitches as described by Patient A.

207. The Tribunal accepted the evidence of Patient A, who confirmed her account when giving oral evidence to the Tribunal. It therefore did not accept the evidence of Mr Steer. It had already decided that Mr Steer and Patient A were in a sexual relationship at this time, and that his denial of this was not credible. Taking out Patient A's stitches was more likely within the context of their relationship, and the Tribunal did not accept the explanation given, noting that the risk of infection for such a minor procedure would be low. The Tribunal agreed with Mr B's assessment that Mr Steer's response did not stand up to scrutiny.

208. The Tribunal decided that it was inappropriate for Mr Steer to have taken out Patient A's stitches. This was because it took place within his home. The Tribunal was also concerned that Mr Steer was in a sexual relationship with Patient A at this time.

209. The Tribunal noted that there was no record that Patient A's stitches had been taken out, and it accepted Mr B's opinion that if they had been taken out, then a record should have been made by Mr Steer.

210. Accordingly, the Tribunal found paragraphs 6(a) and 6(b) of the Allegation proved.

<u>Paragraphs 8(a) and 8(b) of the Allegation</u>

211. The Tribunal took into account the fact that Mr Steer has admitted submitting an appraisal form to King's college Hospital on 10 March 2021, in which he failed to declare that his registration was subject to an open GMC investigation. The Tribunal considered whether Mr Steer knew that his registration was subject to an open investigation at the time of filling out the form, and whether he knew that he was required to declare the investigation on it.

212. The Tribunal firstly considered the appraisal form itself. Section 13 on that Form is entitled '*Probity and Health Statements,'* and in response to the declaration *'In relation to suspensions restrictions on practice or being subject to an investigation of any level since my last appraisal,* Mr Steer ticked '*I have nothing to disclose.'* Underneath this section it states:

'if you have been suspended from any medical post, have restrictions placed on your practice or are currently under investigation by the GMC or any other body since your last appraisal, please declare this here.'

213. The Tribunal took into account the evidence from Ms D, who is an Investigation Adviser at the GMC. She had been assigned the case relating to the complaint that Patient A had made against Mr Steer.

214. The Tribunal noted that Ms D made two statements to the GMC, the first dated 18 March 2022, and the second dated 1 November 2022. She also gave oral evidence at the hearing, confirming the accuracy of her statements.

215. Ms D said in those statements that she opened an investigation into the case involving Patient A and Mr Steer on 26 June 2020 and notified Mr Steer by email dated 27 August 2020. The email states:

'I am writing to inform you of an open investigation into your fitness to practise.'

216. It also enclosed details of the complaint, and information and links to assist with the process. It requested that Mr Steer fill out and return a Work Details Form.

217. The Tribunal noted that Mr Steer responded to Ms Williams by return of email on 27 August 2020 stating:

'Yes I am happy to receive documents
My date of birth is xxx
My post code is xxx
With Kind Regards Chris Steer'

218. The Tribunal noted that Mr Steer then sent another email on 3 September 2020 which states:

'Please find attached the requested documents
I do hope that you will find all to be in order but let me know if anything is missing please.'

219. In considering Ms D s' first statement, the Tribunal noted that she had further correspondence with Mr Steer after the initial introductory letter detailed above. She states:

'On 30 October 2020, Mr Steer asked for an update on the ongoing investigation. I responded on the same day and received a response from Mr Steer, to which I replied on 3 November 2020.'

220. Ms D produced the emails that Mr Steer had sent, and her replies. In the first email of 30 October 2020, Mr Steer asked for an update, and also whether there was any evidence that could be disclosed to him. Ms D responded to that email on the same day, stating that there she anticipated that the witness statement process would be complete by 18 December 2020. Mr Steer emailed again by return, asking if an expert review would take place after 18 December 2020, and Ms D confirmed on 3

November 2020, that was *'the current plan'* and that the expert process can take 6/8 weeks, but could be delayed due to having to find a suitable expert and because of the ongoing COVID-19 pandemic.

221. XXX

222. The Tribunal next considered the evidence from Dr E who was Mr Steer's Responsible Officer (RO) at King's College hospital. Dr E made a statement to the GMC, dated 10 January 2022, and also gave oral evidence at the hearing.

223. In his written statement, Dr E said that he was first made aware of an open investigation against Mr Steer on 9 February 2021 when he received a letter from the GMC informing him of it and requesting that he fill out and return a Fitness to Practice Concerns Form. He therefore sent an email dated 9 February 2021 to Mr Steer which states:

'I have been written to by the GMC in relation to an investigation about concerns involving yourself. I will be responding to the GMC.'

224. In the same email, Dr E pointed out that Mr Steer was still on the hospital computer system, with Dr E as his RO, despite Mr Steer having retired. He stated in the email that he would ask the revalidation team at the hospital to disconnect him from the system, confirming that he would then no longer be his RO.

225. The Tribunal considered the email chain and noted that Mr Steer asked if he could remain on the computer system, so that his appraisal could be finalised on it. This was agreed by Dr E who confirmed in an email dated 12 February 2021 that Mr Steer would be disconnected from the computer system on 15 March 2021.

226. The Tribunal noted that, so far as the GMC investigation was concerned, Mr Steer replied to that email from Dr E on 9 February 2021, on the same day stating;

'I am sorry to hear that the GMC have troubled you I believe this relates to a spurious complaint of over 5 years old duration'

227. The Tribunal noted that the Fitness to Practice Concerns Form was returned by Dr E to the GMC as requested, on 8 March 2021. It states that Dr E did not have any concerns to report.

228. Dr E confirmed in oral evidence that he was not the person conducting Mr Steer's appraisals, and that he was not sure when the last one would have been. He said that they were usually annually, but due to the COVID-19 pandemic, some leeway had been given in 2020, so it would have been at least a year since one was done.

229. Dr E explained in his statement that in April 2021 he filled out a Medical Practice Information Transfer (MPIT) Form, because Mr Steer was no longer connected to the

hospital. He declared on it that Mr Steer had been referred to the GMC. He confirmed that as Mr Steer had reconnected himself to the private company, Circle Health Group, the MPIT form was forwarded to them by the revalidation team on the 28 April 2021. On 6 July 2021, Circle Health Group asked Dr E whether Mr Steer had declared the referral to the GMC on his appraisal form. Dr E had not seen the appraisal form, so he reviewed it, and realised that Mr Steer had not.

230. The Tribunal noted that Dr E confirmed that he then had a further email exchange about the appraisal form with Mr Steer on 16 July 2021. Mr Steer wrote:

'I am really sorry if i did something wrong in my appraisal. I hear that the issue re the GMC 532 complaint is still outstanding.'
…
' I thought when we had a discussion about this and you said the GMC had been in touch with you and that you told them you had no clinical concerns that the matter was closed. I put the matter in my appraisal but didn't discuss with [Mr O] as i discussed with you.'

231. Dr E replied to this email on 19 July 2021. He stated:

'*To be clear - I did not say or imply that the matter was closed with the GMC. I said that I had completed a form for the GMC stating that there were no current fitness to practice to issues with your work at PRUH. > However, accepting that you may have misinterpreted this, what is more concerning is that in Section 13 of your appraisal form - 'Probity' - in response to the question about whether you have been involved in any GMC investigations since your last appraisal, your response was 'No'. > In any event, I am no longer your Responsible Officer, and so these issues now sit with your current Responsible Officer*'

232. In a further exchange of emails on the same day, the Tribunal noted that Mr Steer asked Dr E if he could change his appraisal form, and said:

'I am really sorry if I misunderstood
These events took place 2016 I thought they were over now'

233. In a similar email of the same date, Mr Steer said:

'I thought these allegations from 2016 which were obviously false had long since been resolved I'm so sorry if I misunderstood.'

234. In his oral evidence, Dr E told the Tribunal that he understood the investigation to be about Mr Steer's conduct in relation to XXX who he had operated on while in a sexual relationship with her. He said it was obvious that it had not concluded. Dr E stated that his brief was to comment on any other concerns that there might be that met the fitness to practice threshold, and that he established that there were none. He had not resolved the investigation, nor was it his role to do so. Dr E knew that under

section 11 of the appraisal form, which relates to complaints (rather than investigations), Dr E had declared the complaint by Patient A and had stated '*[Dr]* E *helped to resolve this.'* Dr E stated quite clearly to the Tribunal that this was incorrect and reiterated again that it was not his role to resolve an investigation being conducted by the GMC. Dr E was asked whether he remembered any discussion with Mr Steer about the investigation, and he did not. However, he stated that if there had been a discussion, then he would have said the same as what he was saying to the Tribunal.

235. Dr E told the Tribunal that whether an investigation was open or closed, in his view Mr Steer should have declared it on his appraisal form. He said that a GMC investigation is serious, and not something that a doctor would forget, which is why he said the declaration *'troubled me enormously.'*

236. The Tribunal took into account the explanations that Mr Steer had given in the documents received from him. In the '*Reflections on the CP complaint*' document, dated 12 July 2022, Mr Steer accepts that he did not declare on the appraisal form that his registration was subject to an open investigation, explaining that he should have taken greater care in filling out the document. He explained:

'…I realise now that lack of care and attention to detail in filling in the form had a detrimental effect on faith and confidence in the medical profession.'
…
'I realise now that I should have taken greater care in filling in the appraisal document and taken steps to make sure that I had properly understood what I was being asked to declare.'
…
'Whilst I accept that the error was mine, for the purpose of reflecting upon the error and how to avoid a recurrence, I have identified that being physically and mentally exhausted at the time was a factor.'

237. In Mr Steer's written statement, the Tribunal noted that Mr Steer admitted that he had failed to declare that there was an open GMC investigation on the appraisal form but that he denied that he knew that his registration was subject to the investigation. He explained:

'Following the exchange of emails with Dr E on 9 February 2021 and prior to completing the appraisal form, I recall having a discussion with Dr E during which he informed me that he would be responding to the GMC to say that he had no concerns. I believed this to mean that Dr E had no concerns (a) in respect of the complaint that had been made by Patient A and (b) in more general terms. Upon reflection I realise he may not have meant (a) above and it was my misunderstanding and I should have checked this'.

238. Mr Steer also said in his statement that he had not heard from the GMC, and after the conversation with Dr E he incorrectly thought that was the end of the matter. He said

that he did not recall XXX when he was filling out the appraisal form. He apologised in the statement for the misunderstanding and explained that he had mentioned the complaint on the form and had mentioned it to his appraiser anyway. Mr Steer accepted that even if the investigation had closed, on a better reading of the declaration ie – '*In relation to suspensions restrictions on practice or being subject to an investigation of any level since my last appraisal',* he should have declared it anyway but had misunderstood that he needed to do so.

239. In his oral evidence, Mr Steer explained that he realised that he had to declare the investigation whether it was open or closed, and that, as he said in his *'Reflections'* document, he accepted that this was an error. He said that there would be no point in him purposefully failing to declare the investigation on the appraisal form, because Dr E was his RO, and it would have gone to him anyway.

240. The Tribunal noted that Mr Steer claimed in his evidence that Dr E had known about the GMC investigation when it was first opened in August 2021. He said he was so '*completely overwhelmed and appalled*' that he rang Dr E straightaway and discussed it with him. He said he told Dr E that it was really devastating for him, and he said that Dr E said that he had no issues with him, and that he would help to resolve it. He reiterated that he thought that Dr E had then spoken to the GMC and resolved the matter. He said that the GMC was probably asking Dr E whether the behaviour alleged by Patient A was part of a pattern of behaviour, and that when Dr E told them that he had no concerns, then the investigation would have been closed.

241. In coming to its conclusion, the Tribunal was satisfied that the GMC had opened its investigation after Mr Steer's last appraisal and before he filled out the appraisal form on 10 March 2021, and that it had not closed. It was also satisfied that Mr Steer had been made aware of the investigation. He had last been in contact with the GMC on 3 November 2021, when it was made clear that enquires were still being made. Mr Steer was also in contact with Dr E about the investigation in February 2021.

242. The Tribunal found Mr Steer's explanation that he thought that it had been closed unlikely. He had XXX and had no such notification from the GMC this time. It did not accept that Mr Steer had contacted Dr E when he was first made aware of the investigation, as the email sent by Dr E on 9 February 2021 made no mention of any earlier conversation about it. Mr Steer had not mentioned any earlier discussions of this nature in his written statement and *'Reflections'* document.

243. The Tribunal did not accept Mr Steer's explanation that he thought that, as he had not heard from the GMC, and because Dr E had told the GMC that he had no fitness to practice concerns, that the investigation had closed. The Tribunal determined that it would have been clear to Mr Steer that Dr E had no role to play in resolving the investigation.

244. The Tribunal decided therefore, on the balance of probabilities, that Mr Steer knew that his registration was subject to an open GMC investigation.

245. The Tribunal then went on to consider whether Mr Steer knew that he was required to declare that his registration was subject to an open investigation within the appraisal form.

246. The Tribunal considered the wording of the appraisal form, especially section 13. It decided that it would be clear to any reader that if they were aware of an open investigation against them, then it was incumbent upon them to declare such on the form. The Tribunal decided that section 13 was clear, and that on the balance of probabilities therefore Mr Steer knew that he was required to declare the open investigation.

247. Accordingly, the Tribunal found both paragraphs 8(a) and 8(b) of the Allegation proved.

Paragraph 9 of the Allegation

248. The Tribunal then went on to consider if Mr Steer's omission as described in paragraph 7 was dishonest in light of its findings in paragraph 8(a) and 8(b). When doing so it took account of the advice given by the LQC, and in particular, the case of *Ivey.*

249. The Tribunal has already decided that Mr Steer failed to declare that he was subject to an open GMC investigation when filling out the appraisal form, and that he knew about the investigation at the time that he should have declared it on the form.

250. By making these findings, the Tribunal has not accepted Mr Steer's explanation that he thought the investigation had closed because he had not heard from the GMC, and because Dr E had resolved it for him.

251. The Tribunal noted that Mr Steer said in his *'Reflections'* document that:

'My filling in the form incorrectly led to an eroding of trust between myself and colleagues and by wider implication that of the general public...'

252. In his oral evidence, Mr Steer said that there was no point in him lying on the appraisal form. He said he had not been '*intentionally dishonest, had no reason to be dishonest.'* He said that he had told his appraiser about the investigation, and because Dr E was his RO the form would have gone to him. He said that he had declared the fact of the complaint on section 11 of the form anyway, so he was not hiding anything.

253. The Tribunal did not have the benefit of any evidence from Mr Steer's appraiser to confirm whether he knew of the investigation. It did have evidence that Dr E was not

made aware of the declarations on the appraisal form, and that it was raised with him by Circle Health Group, who Mr Steer had started to work for. It noted that Dr E had informed Mr Steer that he would stop being his RO on 15 March 2021, which was just 3 days after the appraisal form was filled out.

254. The Tribunal decided that, by not declaring the fact of the investigation, but declaring the fact of a complaint and implying that it had been resolved, Mr Steer had downplayed the seriousness of the complaint and the fact that the GMC had become involved.

255. The Tribunal concluded that Mr Steer's explanation of why he did not declare the open investigation on the appraisal form was not credible. It concluded that it was not Mr Steer's genuinely held belief that the GMC investigation had been closed.

256. The Tribunal then applied the (objective) standards of ordinary decent people. It noted that the appraisal from was a formal document, which necessitated a declaration and signature. It decided that Mr Steer, by failing to declare an open GMC investigation, knowing that there was such an investigation and that he was under a duty to declare it, was acting dishonestly.

257. Accordingly, the Tribunal found paragraph 9 of the Allegation proved.

Paragraph 11(b) of the Allegation

258. The Tribunal took into account the fact that Mr Steer has admitted that in the appraisal form he implied that a complaint made against him had been resolved when he stated, '*[Dr]* E *helped to resolve this,'* and that it was untrue. The Tribunal had therefore to decide whether Mr Steer knew that this was untrue at the time of filling out the form.

259. The Tribunal has already decided that Mr Steer failed to declare that he was subject to an open GMC investigation in section 13 of the appraisal form. The Tribunal then considered section 11 of the form and noted that Mr Steer confirmed that he had been the subject of a complaint in the last year. He stated:

'I received one complaint last year.
A XXX from chelsfield complained after helping me at home when I was XXX and subsequently having an emergency laparoscopy by an SR under my care admitted under the care of a colleague but operated on the CEOPD list on a Sunday again when I was on call she nad [sic] allegations about my care that are unfounded. [Dr] E *helped to resolve this.'*

260. The Tribunal again considered the evidence that it had taken into account when deciding that paragraph 8(a), 8(b) and 9 of the Allegation were proved. It considered both the written statements and oral evidence given by Ms D, and in particular Dr E.

261. The Tribunal noted that it was not in dispute that the complaint was still pending at the time the appraisal form was filled out. It was accepted by Mr Steer at the Tribunal that the GMC investigation into the complaint had still been open, and that Dr E had not resolved anything.

262. In his oral evidence, Dr E told the Tribunal that he understood the investigation to be about Mr Steer's conduct in relation to a XXX who he had operated on while in a sexual relationship with her. He said it was obvious that it had not concluded. Dr E stated that his brief was to comment on any other concerns that there might be that met the fitness to practice threshold, and that he established that there were none. He had not resolved the investigation, nor was it his role to do so, and therefore it was incorrect when Mr Steer wrote on the appraisal form that '*[Dr]* E *helped to resolve this.'* He stated that any conversations that there might have been between he and Mr Steer around that time, although he could not now recall them, would not have suggested that he had resolved the complaint.

263. Mr Steer addressed this aspect of the Allegation in his written statement. He said:

'I wrote that "[Dr] E *helped to resolve this" because I thought that the GMC investigation was closed because Dr* E *had no concerns regarding the complaint from Patient A and had communicated to the GMC that he had no concerns. I understand now that Patient A's complaint had not been resolved and that Dr* E *was simply confirming that he had no concerns to report. I therefore admit that this statement was not true. However, I thought at the time that he had helped to resolve the matter.'*

264. In his oral evidence, Mr Steer told the Tribunal that he thought that Dr E had helped to resolve the complaint, and therefore did not accept that the declaration at section 11 was untrue. He said that it was a misunderstanding between him and Dr E after a discussion after the February 2021 email.

265. The Tribunal found Mr Steer's explanation that he thought that Dr E had resolved the complaint to be unlikely. The Tribunal determined that it would have been clear to Mr Steer that Dr E had no role to play in resolving a complaint that he was not involved in. It was not a complaint from that hospital, and the GMC had opened an investigation in relation to it. The Tribunal determined that Mr Steer would have known that Dr E could not resolve such a complaint, and it accepted from Dr E that he had not informed or implied to Mr Steer that he had done so.

266. The Tribunal decided therefore, on the balance of probabilities, that Mr Steer knew that the comment *'[Dr]* E *helped to resolve this'* was untrue when he wrote it on the appraisal form.

267. Accordingly, the Tribunal found paragraph 11(b) of the Allegation proved.

Paragraph 12 of the Allegation

268. The Tribunal then went on to consider if Mr Steer's action as described in paragraph 10 was dishonest in light of Mr Steer's admission to paragraph 11(a) and its finding at paragraph 11(b). Again, when doing so, it took account of the advice given by the LQC, and the case of *Ivey.*

269. The Tribunal has already decided that Mr Steer implied on the appraisal form that '*[Dr]* E *helped to resolve this',* and that at the time he knew that the comment was untrue. Again, by making this finding, the Tribunal has not accepted Mr Steer's explanation that he had discussed the matter with Dr E and that there had been a misunderstanding such that he thought that the complaint had been resolved.

270. The Tribunal took into account again the account given by Mr Steer in his oral evidence. He said that there was no point in him lying on the appraisal form. He said he had not been intentionally dishonest. He said that, as Dr E was his RO, the form would have gone to him and so he would have noticed what Mr Steer had written at section 11.

271. The Tribunal noted that Dr E was not made aware of the declarations on the appraisal form, and that it was raised with him by Circle Health Group. It noted again that Dr E had informed Mr Steer that he would stop being his RO on 15 March 2021, 3 days after the appraisal form was filled out.

272. The Tribunal decided that, by implying that Dr E had resolved the complaint, Mr Steer was downplaying the complaint and was also failing to declare that the complaint was still pending and with the GMC for investigation.

273. The Tribunal concluded that Mr Steer's explanation of why he wrote the comment on the appraisal form was not credible. It concluded that it was not Mr Steer's genuinely held belief that Dr E had resolved the complaint.

274. The Tribunal then applied the (objective) standards of ordinary decent people. It noted again that the appraisal from was a formal document, which necessitated a declaration and signature. It decided that Mr Steer, by implying that his RO, Dr E, had helped to resolve the complaint was acting dishonestly.

275. Accordingly, the Tribunal found paragraph 12 proved.

The Tribunal's Overall Determination on the Facts

1. On 19 December 2015 you:

   a. inappropriately operated on Patient A ('Procedure One'):

i. as you performed a hysteroscopy when there was no clinical indication;
Determined and found proved

ii. as you performed a laparoscopic uterine nerve ablation:

1. as a course of action over and above treatment of any endometriosis;
Determined and found proved

2. when it was not clinically indicated;
Determined and found proved

b. failed to obtain informed consent from Patient A for Procedure One.
Determined and found proved

2. Between February 2016 and September 2016, whilst Patient A remained your patient, you:

a. engaged in conversations with Patient A by way of WhatsApp messages in which you:

i. offered to do Patient A a private scan free of charge, or words to that effect; Admitted and found proved

ii. commented on how attractive you found Patient A;
Determined and found proved

iii. invited Patient A to meet you for drinks;
Determined and found proved

iv. on one or more occasion asked Patient A to go to your house;
Admitted and found proved

b. pursued an improper emotional relationship with Patient A.
Determined and found proved

3. Your actions as described at paragraph 2 were sexually motivated.
Determined and found proved

4. Between November 2016 and April 2017, whilst she remained your patient, you engaged in a sexual relationship with Patient A.
Determined and found proved

5. On 19 February 2017 you assisted in Patient A's surgery despite Patient A's request that you not be involved.

Determined and found proved

6. In or around March 2017 you examined Patient A and removed her stitches and:

a. the examination was inappropriate as it took place at your home address; Determined and found proved

b. you failed to record this consultation in Patient A's medical records. Determined and found proved

7. On 10 March 2021, you submitted an appraisal form ('the Appraisal Form') to King's College Hospital NHS Foundation Trust in which you failed to declare that your registration was subject to an open GMC investigation.
Admitted and found proved

8. You knew that:

a. your registration was subject to an open GMC investigation at the time you submitted the Appraisal Form;
Determined and found proved

b. you were required to declare that your registration was subject to an open GMC investigation within the Appraisal Form. Determined and found proved

9. Your omission as described a paragraph 7 was dishonest by reason of paragraphs 8.a and 8.b. Determined and found proved

10. In the Appraisal Form you implied that a complaint made against you had been resolved when you stated '[Dr B] helped to resolve this'. Admitted and found proved

11. The comment included at paragraph 10 above:

a. was untrue; and
Admitted and found proved

b. you knew it to be untrue.
Determined and found proved

12. Your action as described at paragraph 10 was dishonest by reason of paragraphs 11.a and 11.b. Determined and found proved

Determination on Impairment - 22/04/2025

1. 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, Mr Steer's fitness to practise is impaired by reason of misconduct.

The Evidence

2. In reaching its determination, the Tribunal took into account the evidence that it had received during the facts stage of the hearing. The Tribunal found that Mr Steer had inappropriately operated on Patient A by performing both a hysteroscopy and a LUNA when they were not clinically indicated. It also found that Mr Steer engaged in conversations with Patient A on WhatsApp and pursued an improper emotional relationship with her which was sexually motivated. The Tribunal had decided that this relationship became a sexual one which lasted between November 2016 and April 2017, and that during this period of time, Mr Steer assisted in Patient A's surgery when she asked him not to be Involved and later took her stitches out at his home. Further, the Tribunal found that Mr Steer acted dishonestly in two respects when completing his appraisal form in March 2021.

3. The Tribunal received no further documentary evidence from the GMC at this stage of the hearing. Mr Steer did not give oral evidence, but he did provide some further documentary evidence including:

- A Reflections document headed 'Reflections on Outcome of Hearing Stage 1 CV Steer' ('the Reflections document'),
- Testimonial dated 15 November 2021 from Ms G, Consultant Obstetrician & Gynaecologist/Oncology Lead
- Testimonial dated 16 November 2021 from Mr H, Upper Gl, Bariatric & Laparoscopic Specialist
- Character Reference dated 17 November 2021 from Miss I
- Consent Audit
- CPD Certificates
- A number of medical and research documents relating to endometriosis.

Submissions on Impairment

The GMC

4. Mr Rigby reminded the Tribunal that the determination on impairment is a matter for its judgment and that there is no burden or standard of proof. He said that there is a two-stage procedure. The Tribunal must first decide whether Mr Steer's actions amount to misconduct and if so then decide if his fitness to practise is currently impaired. He informed the Tribunal that to find misconduct, the actions must be serious misconduct in the practise of the profession, and/or such as would be described by fellow professionals as '*deplorable*' or '*disgraceful*'. He also drew the Tribunal's attention to the guidance it should follow regarding impairment as set out by Dame Janet Smith in the 5th report of the Shipman Enquiry.

5. Mr Rigby stated that the Tribunal should always bear in the mind the overarching objective and take into account Good Medical Practice 2013(GMP). He also referred to the case of *Cohen v. GMC [2008] EWHC 581 (Admin),* submitting that the relevant factors in determining impairment are whether a doctor's conduct is easily remediable, whether it has been remedied, and whether it is highly unlikely to be repeated. He submitted that insight is a crucial component of remediation.

6. Mr Rigby addressed the Tribunal about the conduct that it had found proved, setting out that there were three areas of conduct to be considered- clinical malpractice, sexual misconduct and dishonesty.

7. In relation to clinical malpractice, Mr Rigby drew the Tribunal's attention to the facts, and Mr B's expert evidence which the Tribunal had accepted. He submitted that the aggravating factors relating to the operation on 19 December 2015 were the young age of the patient, the '*rush to surgery'* after the consultation, the risk of harm, and Mr Steer's '*arrogance'* in not adhering to the Guidelines. He said in mitigation, that it seems likely that Mr Steer thought he was doing the best for patient, and that Mr Steer showed partial insight in his acceptance that the consent he obtained was not gold standard, though his overall approach was that he did nothing significantly wrong.

8. In relation to sexual misconduct, Mr Rigby reminded the Tribunal that it had found that Mr Steer had pursued an improper emotional relationship with Patient A which was sexually motived, which later developed into a sexual relationship. He submitted that the aggravating features were that Patient A was a patient at the time, and also a work colleague who Mr Steer had influence over. He pointed out her youth, the age disparity between them, and the breach of trust. He submitted that there were no mitigating factors. So far as conducting the operation on 19 February 2017 was concerned and taking out Patient A's stitches thereafter, Mr Rigby said that again there was a breach of trust, and that Patient A and Mr Steer were then still in a sexual relationship. He conceded that it could be a mitigatory factor that there was no practical alternative at the time.

9. In relation to the dishonesty on the appraisal form, Mr Rigby stated that the dishonesty itself was the aggravating factor.

10. Mr Rigby then addressed that Tribunal about whether the facts proved amounted to serious misconduct.

11. In relation to the clinical malpractice, Mr Rigby stated that Mr Steer's conduct was in breach of GMP at paragraphs 1, 2, 7, 8, 11, 12, 15, 17 and 65. He said that the Tribunal may conclude that the unnecessary and potentially dangerous operation carried out by Mr Steer and the lack of informed consent would be viewed as deplorable by colleagues if taken either separately or together.

12. In relation to the sexual misconduct, Mr Rigby drew the Tribunal's attention to Paragraph 149 and 150 of the Sanctions Guidance (SG) which provides:

> *'This encompasses a wide range of conduct from criminal convictions for sexual assault … to sexual misconduct with patients and colleagues.'*

And

> *'Sexual misconduct undermines public trust in the profession. The misconduct is particularly serious where there is an abuse of the special position of trust a doctor occupies.'*

13. Mr Rigby also drew the Tribunal's attention to GMP and stated that the Tribunal might find that Mr Steer had breached a number of its paragraphs, namely 1, 2 , 53 and 65. He said that colleagues would find Mr Steer's behaviour deplorable, and, on any view, it would be serious misconduct.

14. In relation to the dishonesty on the appraisal form, Mr Rigby submitted that the dishonest falsification of so important a record as an appraisal is almost by definition, serious, and that it was in breach of GMP at paragraphs at 1, 65 and 71. He said that colleagues and the public would regard this conduct as deplorable and that it is obviously serious misconduct.

15. Mr Rigby then addressed the issue of current impairment. He pointed out that the SG emphasises the importance of insight at paragraphs 42, 45 and 46. He referred to the Reflections document that Mr Steer produced at this stage and said that there were some elements of insight in it. Mr Steer had said that he accepts the Tribunal findings and understood their gravity and had conceded that the operations had not succeeded. Mr Steer had also expressed regret, albeit only in 2025, a very long time after the conduct. He had also produced some evidence of courses he had attended and had accepted that the consent form was inadequate.

16. However, Mr Rigby also pointed out that there was no evidence of an apology to Patient A, and that he had *'traduced'* her character during the facts stage. He had not accepted the dishonesty findings, although he conceded that the appraisal form was untrue. Not much had happened since 2021 in terms of training and remediation. He pointed out that Mr Steer '*rows back'* from his acceptance of the findings when he gave further detail in the Reflections document, and that there was an element of rearguing the factual issues. In terms of boundary violations, Mr Rigby said that Mr Steer was a long way from insight, because he was still maintaining that these allegations were untrue, and all that he conceded was that he accepted that he should not have asked Patient A to give him care.

17. Mr Rigby went through the timeline of the case, stating that the allegations ranged from December 2015 to March 2021. He pointed out that the testimonials received by the Tribunal were dated in 2021, coinciding with an Interim Orders Tribunal hearing, and did not address the allegations made by the GMC in any depth. There were no new or recent testimonials.

18. Mr Rigby summarised by stating that the Tribunal could find serious misconduct for clinical malpractice, sexual misconduct, and dishonesty. He also said that the Tribunal might find that it was in the public interest to make a finding of impairment for the sexual misconduct and the dishonesty, and that a member of the public would be surprised and shocked if it did not do so.

Mr Steer

19. Mr Steer thanked the Tribunal for giving him the opportunity to address it. He then began by describing the operation that took place on 19 December 2015 and stated that he was aware of what the expert, Mr B had said, and that in retrospect perhaps the procedures were not clinically indicated. He explained that he had requested the medical records for Patient A because he knew that three other consultants had done the same as him, and that it was standard practice to repeat procedures to see if there was anything that had been missed. He accepted that Mr B takes a different view, and that he therefore will not do it again. He referred to the up-to-date documents relating to endometriosis that he had provided to the Tribunal. He explained that there had been research findings that male doctors were not giving the right treatment when women were in pain. He said that Patient A was in pain, and on morphine, and that he thought it best to get rid of it.

20. Mr Steer accepted that over the last ten years, there had been a change in medical advice, and that a new tablet had been authorised, known as Relugolix CT. This was better than the Zoladex that was available in 2015 because the pain relief is more immediate, and there are fewer side effects. He said that now '*rushing off to surgery'* would not be the best idea.

21. Mr Steer also addressed the Tribunal about the consent form. He said that he had thought that there was a three-stage process, which included information being given at clinic, handouts being provided, and then the signing off stage before the procedure. He now realised that this was not the gold standard. He said that if he were allowed to return to work, he would use the standardised consent form that he had found in the RCOG Guidelines, or the forms that any hospital requested that he use. He said he would put down all the risks and benefits as required by the guidance.

22. Mr Steer said that it was extremely difficult on 19 February 2017 when Patient A had been admitted to hospital. He was the consultant on call, and if he were not going to oversee the procedure at all then he would have had to call another consultant to come in. It was difficult because Patient A was lying on the ward on morphine and in pain. There was just him, the Senior House Officer and a Registrar on duty. He said that he was not the operating surgeon. If he had been scrubbed, then there would be nobody covering the labour ward. He did not accept the operation note was accurate.

23. Mr Steer said that he was extremely grateful to Patient A for the care that she gave him when he had injured XXX. Because he had been injured and treated in XXX, he had not been able to access proper care through the NHS and he was living on his own. He said that he had been practising for 35 years and had worked with many young women, and up until

then had never socialised out of work and there had been no complaints. He said that he was '*so stupid*' to have allowed Patient A to come to his home, even though he said that she was not his patient at the time, because he was off work due to his XXX injury. He said that he had now attended a Professional Boundaries Course and accepted that inviting Patient A to his home was a breach of professional boundaries and it would not happen again. He accepted that it was wrong and open to misinterpretation. He also said that he was sorry that he had got into the situation regarding the stitches, but that he had known Patient A for a year, and she was a XXX.

24. Mr Steer apologised to Patient A and said that he was aware that she had XXX and that he wished her well.

25. Mr Steer explained that he was now 67 years of age, and that he qualified in 1982, when life was very different. He said that he and his colleagues all worked over 100 hours a week and lived in residences together. They all collectively helped each other, and he had kept that mentality, which he now accepted was wrong. He said that he now understood the boundaries, and that if he were injured in future, he would ensure that the NHS helped him.

26. Mr Steer asked the Tribunal to consider the three testimonials that he had provided and stated that there were dated in 2021 because he had not been able to work since the allegations.

27. When addressing the dishonesty on the appraisal form, Mr Steer said that he was really upset and feels that he had been '*very stupid*' for not ticking the right boxes. He said that he did not consider that what he was doing was dishonest at the time, and that it was not intentional. He said that he had discussed the complaint from Patient A with Dr E, but that it was stupid to think that it had gone away. He said that he did have insight that the form was incorrect.

28. Mr Steer explained that he had not worked for 4 years and that there was now no possibility of him returning to private practice, which he did not want to do anyway. He said that he felt that he could, however, do NHS work, rather than sitting at home all day. He felt that in the past he had been contributing to society, and that he still had the skills to do the work in the future. Mr Steer said this had been a '*terrible situation*' for him and that he had been doing nothing at home, apart from taking courses and reading guidelines. He felt that he could again be useful.

The Relevant Legal Principles

29. The LQC gave legal advice which is summarised below:

> There is no burden or standard of proof to adopt at this stage and the decision as to impairment is a matter for the Tribunal's judgement alone.

There are 2 parts to the impairment stage of the process. Firstly, the Tribunal must decide whether the facts as found proved amount to misconduct, and then whether the finding of that misconduct leads to a finding of current impairment.

'Misconduct' has no statutory definition. It is a matter for the judgement and experience of the tribunal. However, in the case of *Roylance v GMC [No 2] [2000] 1 AC 311* it was said that 'misconduct' should be 'serious professional misconduct' before the Tribunal should move to consider fitness to practise. The word 'serious' should be given its ordinary meaning.

The Tribunal should take into account whether Mr Steer has departed from the standards sets out in GMP 2013. The Tribunal has received evidence from an expert, Mr B 's, and his opinion can be taken into account at this stage so far as the clinical issues are concerned. The Tribunal does not have to accept the expert opinion, but if it decides not to accept it, then it must set out our reasons why that is the case.

In the case of *Nandi v GMC [2004] EWHC*, C*ollins J* said that misconduct can also be conduct which would be regarded as 'deplorable' by fellow practitioners. And in the case of *R (Remedy UK Limited v GMC [2010] EWHC 1245 (admin)* it states that misconduct; *'can involve misconduct of a morally culpable or otherwise disgraceful kind.'*

Generally, each instance of misconduct should be considered separately, as to whether it on its own is serious misconduct. However, as there are a number of different aspects of misconduct forming this Allegation, the Tribunal is asked to regard the case of *Schodlok v GMC [2015] EWCA Civ 769,* which considered whether a Tribunal could find whether paragraphs which on their own may be misconduct but not serious misconduct, could cumulatively amount to serious misconduct. The case states that generally it cannot. But LJ Vos does state that if there are a large number of findings of non-serious misconduct, particularly where they are of a similar nature and show a pattern of behaviour, then it is open in principle for the Tribunal to find that cumulatively, they are to be regarded as serious misconduct capable of impairing a doctor's fitness to practice.

If, having decided that there is misconduct as defined, then the Tribunal should go onto impairment. It is not necessarily the case that if misconduct is found, impairment must follow.

Whilst there is no statutory definition of impairment, the Tribunal is assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927 (Admin)* ('Grant'). Dame Smith sets out some features that are likely to be present when impairment is found. These are where a doctor has in the past or is liable in the future to

a. act so as to put a patient or patients at unwarranted risk of harm; and/or

b. bring the medical profession into disrepute; and/or

c. breach one of the fundamental tenets of the medical profession; and/or

d. have acted dishonestly and or is liable to do so in the future.

The Tribunal is informed that it should take into account Mr Steer's hitherto good character and the testimonials when making a determination on impairment.

The Tribunal is reminded that part of the Allegation relates to dishonesty. In the case of *GMC v Nwachuka 2017 EWHC 2085 Admin* it was confirmed that it is unusual for dishonesty not to result in impairment. Also, the case of *Nkomo v GMC 2019 EWHC 2625 admin* states that dishonesty is generally held to be difficult to remediate. This is because, unlike with clinical errors, where further practice and/or teaching would likely show a practitioner the correct method of practice, the nature of dishonest behaviour goes more to the practitioner's *character* than learning. Clinical and personal mitigation therefore hold less weight in such cases.

In similar vein, the Tribunal is also reminded that part of the Allegation relates to behaviour that was found by the Tribunal to be sexually motivated, which again, goes to character, and so is seen as more difficult to remediate.

Having said that, the Tribunal must note that each case is determined on its own facts. Impairment does not necessarily follow findings of either dishonesty or sexually motivated misconduct. The Tribunal should look at the circumstances of the case, the need to uphold public confidence, and what has been done to remediate.

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

The Tribunal should note that Mr Steer denied the majority of the Allegation. By finding all matters proved, the Tribunal has rejected Mr Steer's defence. It is advised, however, that it should not necessarily equate the maintenance of innocence with a lack of insight. The recent case of *Sawati v GMC [2022] EWHC (admin) circular* deals specifically with rejected defence cases and how they should be treated at the impairment and sanction stage. A tribunal should not punish a doctor for defending himself, as he is entitled to do so, but it can weigh up what happened at stage one when assessing insight. The Tribunal should look to see what other evidence there is about the doctor's insight and understanding of the conduct. It is possible that a doctor who maintains his innocence can still demonstrate that he fully appreciates the gravity of the matters alleged and it is proper to take into account a doctor's understanding of, and attitude toward the underlying allegation.

The Tribunal must also determine whether the need to uphold professional standards and maintain public confidence would be undermined if a finding of impairment were not found. The case of *Grant* makes it clear that protecting the public and upholding proper standards and public confidence in the profession is a fundamental consideration. The Tribunal was asked to note the principle in the case of *Yeong v GMC* [2009] EWHC 1923 Admin, that:

> '*There will be occasions where impairment of fitness to practice must be found as a matter of public policy to uphold public confidence in the profession where to make no such finding would have an adverse impact on public confidence in the profession*.'

Also, in the case of *Cheatle v GMC [2009] EWHC 645 (admin)* it was stated that a doctor's behaviour at a particular time maybe *'so egregious'* that, looking forward, a Tribunal may be persuaded that a doctor is not fit to practise.

It is crucial that the Tribunal is mindful at all times of the overarching objective set out in s1 of the Medical Act 1983 which requires the Tribunal to:

a. Protect, promote, and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

The Tribunal's Decision

30. The Tribunal carefully considered all the evidence that it had taken into account when it found the Allegation proved, as well as the new documentary evidence produced at this stage by Mr Steer. The Tribunal also listened carefully to the submissions made by both parties and accepted the LQC's advice.

Misconduct

31. The Tribunal first considered whether the facts found proved amounted to serious professional misconduct. It noted that the Allegation included aspects involving clinical practice, sexual misconduct, and dishonesty.

Paragraphs 1(a)(i) – (ii)

32. The Tribunal reminded itself of the facts that had been alleged in paragraph 1 of the Allegation. They related to a procedure that took place on 19 December 2015. The Tribunal had determined that Mr Steer performed both a hysteroscopy when it was not clinically

indicated, and a LUNA as a course of action over and above treatment of endometriosis, which was again not clinically indicated.

33. The Tribunal had accepted and relied on the evidence given by Mr B when it found paragraph 1 proved. The Tribunal decided to again rely on Mr B's evidence for this misconduct and impairment stage.

34. The Tribunal noted that Mr B had said that it was not appropriate to conduct this procedure, and to carry out either a hysteroscopy or a LUNA. He said that a LUNA was contrary to the accepted NICE Guidelines dated 2007. He had told the Tribunal in his oral evidence that it was *'very clear'* that a LUNA should not have been carried out because it was an outdated procedure. He said that a LUNA was not appropriate for a young patient who has not yet had children. He said that the threshold for surgery in Patient A's case was too low, and that she was placed on an accelerated surgery pathway. He said that because an operation is invasive, then there is always a risk of injury to other organs, or of scarring. He said that Mr Steer should have promoted medication or injections rather than conduct the procedure, and that an MRI scan could have been carried out if Mr Steer were concerned about deep deposits of endometriosis.

35. The Tribunal noted that in his report dated 24 June 2021, Mr B was asked to state the specific aspects of the procedure that were seriously below the standard expected of a reasonably competent Consultant Gynaecologist. His report reads:

> *'c. State the specific aspects which were seriously below the standard;*
>
> *(i) Mr Steer undertook not only a laparoscopy with treatment of endometriosis but also proceeded with a laparoscopic uterine nerve ablation and hysteroscopy on a [XXX]-year-old.*
>
> *d. Explain why they were seriously below?*
>
> *(i) Neither procedure was clinical indicated. The laparoscopic uterine nerve ablation was performed despite earlier published NICE Guidelines that this operation should not be carried out. Patient A was at risk of complications from both procedures which could have been significant.'*

And then:

> *'Overall standard*
>
> *9. Please explain whether the overall standard of care was not below, below or seriously below the standard expected of a reasonably competent Consultant Gynaecologist and your reasons for this overall conclusion.*

The overall standard of care was seriously below the standard expected of a reasonably competent Consultant Gynaecologist as unnecessary surgical interventions were carried out in December 2015'

36. The Tribunal also took account of the joint expert report dated 16 March 2023, drafted by both Mr B and Professor C. It noted that Professor C agreed that a hysteroscopy was not indicated, and in his view, conducting this part of the procedure fell below the standard required of a reasonably competent consultant gynaecologist. He also agreed that the LUNA was an outdated procedure.

37. The Tribunal considered Mr Steer's explanation for carrying out the procedure. He had asserted when giving oral evidence at the facts stage that a hysteroscopy was clinically indicated and that a LUNA procedure was carried out to treat the pain being caused by Patient A's endometriosis. He said that he was aware that he was breaching the NICE Guidelines but said that he thought that he was doing his best for Patient A who was experiencing significant pain.

38. The Tribunal accepted from Mr B that conducting the procedure (which comprised both the hysteroscopy and the LUNA) fell far below the standard required of a reasonably competent Consultant Gynaecologist. It also had regard to the NICE Guidance, which states in its headline that LUNA *'is not efficacious and therefore should not be used.'* The Tribunal accepted from Mr Steer that he had conducted the procedure to try to alleviate pain but it was concerned that he had purposefully contravened the NICE Guidelines and put Patient A at risk.

39. The Tribunal then considered paragraphs 1, 2, 7, 8, 15, 16(a) and 16(b) and 65 of GMP. They read:

1 'Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues are honest and trustworthy, and act with integrity and within the law.

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

…

7 You must be competent in all aspects of your work, including management, research and teaching'.

8 You must keep your professional knowledge and skills up to date.

…

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients.

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.

b provide effective treatments based on the best available evidence.

…

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

40. Having considered Dr B's evidence and Mr Steer's explanations, the Tribunal decided that Mr Steer's actions breached paragraphs 1, 2, 15, 16(a) and 16(b) and 65 of GMP. The Tribunal decided that paragraph 7 applied because Mr Steer had conducted a procedure that was not clinically indicated. It decided that paragraph 8 applied because Mr Steer had conducted a procedure that was outdated.

41. The Tribunal also decided that by conducting both the hysteroscopy and the LUNA, Mr Steer had fallen far below the standards expected of a reasonably competent consultant gynaecologist, and that Patient A had been put at unwarranted risk of harm. He had breached a fundamental tenet of the medical profession, and this constituted serious misconduct in the practise of the profession.

42. The Tribunal concluded therefore that Mr Steer's actions in conducting the hysteroscopy and a LUNA on 19 December 2015 both separately, and taken together as one procedure, amounted to serious professional misconduct.

Paragraph 1(b)

43. The Tribunal reminded itself of the facts that had been alleged in paragraph 1(b) of the Allegation. They related to Mr Steer's failure to obtain informed consent before the procedure on 19 December 2015.

44. The Tribunal noted that the consent form completed by Mr Steer and signed by both Mr Steer and Patient A, did not list any benefits, and the only risk listed was *'bleeding'*. At the facts stage, Mr B had drawn the Tribunal's attention to the RCOG Guidelines (Consent Advice number 2), on obtaining consent for a hysteroscopy which is dated December 2008. The Tribunal noted that this Guidance sets out the serious and frequently occurring risks in an operation of this nature which should be addressed in a consent form. Mr B said that these risks should have been addressed with Patient A, even though she had undergone previous

laparoscopies. He explained that in his view, Patient A was, because of her age, more vulnerable and susceptible to any advice and recommendations given by Mr Steer and would therefore be expected to be more agreeable to the suggested interventions in the absence of an adequate explanation of the risks and benefits, and possible alternative approaches. He said that '*Dr Steer's actions set the scene for an unacceptable surgical trajectory for Patient A without medical alternatives.'*

45. In his supplemental report dated 7 July 2023, the Tribunal noted that Mr B addressed the standard expected of a reasonably competent consultant gynaecologist so far as obtaining informed consent is concerned. He said:

> *'The Consent Form completed by Mr Steer on 19 December 2015 was incomplete and below the expected standard given the nature of the proposed surgery which included inappropriate interventions with distinct risks (hysteroscopy and uterine nerve ablation). The experts have agreed that Mr Steer failed to obtain appropriate informed written consent from Patient A for Procedure 1 and that fell seriously below the expected standard for a reasonably competent Gynaecologist.*

46. The Tribunal noted that the joint expert report confirmed both Mr B and Professor C's opinion. It stated:

> *'[XXX] – Agreed. Mr Steer failed to obtain appropriate informed written consent from Patient A for Procedure 1 and that fell seriously below the expected standard for a reasonably competent Gynaecologist.'*

47. The Tribunal considered Mr Steer's explanation about the consent form. When he gave oral evidence at the facts stage, he conceded that the form did not meet '*the gold standard*' and that it was not adequately completed. He explained that as Patient A was a XXX in the clinic, she knew what the operations were about anyway and that *'it was very easy to frighten a patient,'* so he only put down the risks that he thought applied to his procedures.

48. The Tribunal accepted from Mr B that the omission to obtain fully informed consent fell far below the standard required of a reasonably competent consultant gynaecologist. It also had regard to the RCOG Guidance on consent which Mr Steer had not followed. The Tribunal was concerned that Patient A was young, vulnerable, and given very little time to consider the other non-surgical options that were available.

49. The Tribunal then considered paragraphs 11, 12 and 17 of GMP, as well as paragraph 65 quoted above. They read:

> *'11 You should check whether patients have understood the information they have been given, and whether or not they would like more information before making a decision. You must make it clear that they can change their mind about a decision at any time.'*
>
> *12 You must be familiar with guidelines and developments that affect*

your work.

…

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.'

50. Having considered Mr B's evidence and Mr Steer's explanations, the Tribunal decided that Mr Steer's omission to obtain informed consent for the procedure breached these paragraphs. The Tribunal decided that paragraph 17 applied not because no consent had been obtained, but because the consent that was obtained was inadequate and not fully informed.

51. The Tribunal also decided that Mr Steer's omission to obtain informed consent fell far below the standards expected of a reasonably competent consultant gynaecologist. It concluded that Patient A had not been properly informed of the risks and benefits to the procedure, and that this lack of consent was exacerbated by the fact that hysteroscopy and LUNA should not have been conducted in any event. It breached a fundamental tenet of the medical profession and constituted serious misconduct in the practise of the profession.

52. The Tribunal concluded therefore that Mr Steer's omission in not obtaining fully informed consent amounted to serious professional misconduct.

Paragraphs 2(a)(i), (ii), (iii), (iv) and 3

53. The Tribunal reminded itself of the facts that had been alleged in paragraph 2 and 3 of the Allegation. The Tribunal had found that Mr Steer sent a large volume of WhatsApp messages to Patient A between February 2016 and September 2016, offering to do a private scan free of charge for her, commenting on how attractive she was, inviting her for drinks, and asking her to go to his home. The Tribunal had accepted the evidence given by Patient A, and not the explanation given by Mr Steer. It had accepted that the schedule of WhatsApp messages produced by Patient A was accurate, and concluded that the messages and their context, along with the evidence that Patient A gave, clearly demonstrated that Mr Steer was pursuing an emotional relationship during this period of time, and that his actions were sexually motivated.

54. The Tribunal concluded that Mr Steer's actions demonstrated a marked lack of appreciation for professional boundaries. It decided that he was using his professional relationship to pursue an improper emotional and sexual relationship with a patient and work colleague. The Tribunal noted that Patient A had gynaecological issues that Mr Steer was treating. It also noted that he was a senior consultant, and she a junior XXX. There was a notable age disparity and power imbalance. The Tribunal therefore decided that the developing relationship involved a breach of trust.

55. The Tribunal decided therefore that Mr Steer's actions in pursuing a relationship with Patient A breached a number of paragraphs of GMP. The Tribunal particularly considered paragraphs 36, 37 and 53 of GMP. These read:

> *'36 You must treat colleagues fairly and with respect.*
>
> *37 You must be aware of how your behaviour may influence others within and outside the team.*
>
> *…*
>
> *53 You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.'*

56. The Tribunal also decided that Mr Steer's conduct in this regard could be regarded as *'deplorable'* by fellow practitioners, and that it would be seen as *'disgraceful'* behaviour and morally reprehensible. His actions could undermine public confidence and fell below the professional standards expected of the medical profession.

57. The Tribunal concluded therefore that Mr Steer's actions in pursuing the relationship with Patient A constituted serious misconduct.

Paragraph 4

58. The Tribunal reminded itself of the facts that had been alleged in paragraph 4 of the Allegation. The Tribunal had found that between November 2016 and April 2017, Mr Steer had a sexual relationship with Patient A.

59. Again, the Tribunal reminded itself of the account given by Patient A which it had accepted at the facts stage. She described that their relationship turned into a sexual relationship after 4 November 2016, and that it continued for several months. She had produced the WhatsApp schedule which demonstrated that their relationship had become intimate.

60. In similar vein to the findings relating to paragraphs 2 and 3 of the Allegation, the Tribunal concluded that Mr Steer's actions were improper. Again, it noted the age disparity, the fact that Patient A remained a patient and work colleague during this period of time, the power imbalance and breach of trust. The Tribunal decided therefore that Mr Steer's actions in engaging in a sexual relationship with Patient A breached the same paragraphs of GMP, namely paragraphs 36, 37 and 53 of GMP, set out above.

61. The Tribunal also decided that engaging in this sexual relationship could be regarded as *'deplorable'* by fellow practitioners and would be seen as *'disgraceful'* behaviour. His actions could undermine public confidence and fell below the professional standards expected of the medical profession.

62. The Tribunal concluded therefore that Mr Steer's actions in engaging in a sexual relationship with Patient A constituted serious misconduct.

Paragraph 5

63. The Tribunal reminded itself of the facts that had been alleged in paragraph 5 of the Allegation. The Tribunal had found that Mr Steer had assisted in Patient A's surgery on 19 February 2017, despite Patient A asking that he not be involved.

64. The Tribunal noted that Patient A said in her GMC statement that she did not want Mr Steer to be involved in this procedure because they were in a sexual relationship at the time, and she thought that he might get into trouble.

65. The Tribunal took account of the expert evidence relation to this paragraph, even though it saw Mr Steer's actions as being related to professional boundaries rather than clinical performance. In his supplementary report of 7 July 2023, Mr B stated:

> *'….This was inappropriate as by then he was in an intimate relationship with Patient A who had asked that he not perform the procedure. It was not appropriate for him to treat or examine Patient A at his home either. The experts have agreed that if Mr Steer directly assisted in the operation, contrary to the expressed wishes of Patient A, then this would fall seriously below the standard for a reasonably competent consultant gynaecologist.*

66. In their joint report dated 16 March 2023, Mr B and Professor C stated:

> *'[XXX] – … Both agreed that if Mr Steer directly assisted in the operation, contrary to the expressed wishes of Patient A, then this would fall seriously below the standard for a reasonably competent consultant gynaecologist.'*

67. The Tribunal took into account the fact that Mr Steer said that it would have been difficult to find another consultant at the time. It accepted that there could have been such practical difficulties but noted that Mr B was of the view that it was questionable whether the procedure was an emergency, and it decided that other arrangements should have been made.

68. The Tribunal concluded that Mr Steer should not have assisted in Patient A's surgery against her express wishes, and also because he was still in a sexual relationship with Patient A at the time. It accepted from the experts that in so doing, his actions fell seriously below the standards required of a reasonably competent consultant gynaecologist.

69. The Tribunal decided therefore that Mr Steer's actions in being involved in the operation breached a number of paragraphs of GMP. The Tribunal had regard to paragraphs 1, 16(g), 17 and 65 of GMP which state:

'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues are honest and trustworthy, and act with integrity and within the law.

....

16 In providing clinical care you must:

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.

....

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

70. The Tribunal decided that Mr Steer had again crossed professional boundaries. The Tribunal took the view that his actions could undermine patient and public confidence and fell below the professional standards expected of the medical profession.

71. The Tribunal concluded therefore that Mr Steer's involvement in this operation amounted to serious professional misconduct.

Paragraphs 6a and 6b

72. The Tribunal reminded itself of the facts that had been alleged in paragraph 6 (a) and 6(b) of the Allegation. The Tribunal had found that, in March 2017, after the operation on 19 February 2019, Mr Steer had examined Patient A, and removed her stitches at his home address, and failed to record this consultation.

73. The Tribunal had accepted the account given by Patient A that after the operation, Mr Steer started to message her again, and she went round to his house. She said he took out her stitches with tweezers and a pair of scissors while she lay on the bed. She had been told that she could not return to work until the stitches had been removed or dissolved, and so she allowed Mr Steer to take them out so that she could return to work sooner.

74. The Tribunal again took account of the expert evidence. In their joint report dated 16 March 2023, both Mr B and Professor C stated:

'[XXX] – Agreed. If the stitches were removed at Dr Steer's home address, then unless this was in the context of a private consultation and he was officially

consulting private patients at home, then removal of the stitches at his home address fell below the expected standard.'

75. In the joint report, Mr B stated that it was inappropriate for Mr Steer to take out the stitches because he was still in a sexual relationship with Patient A at the time, and that doing so, along with failing to record such a consultation fell below the professional standard required. Professor C stated that, in the absence of having medical records to write in at the time, an omission to do so would not fall below the required standard.

76. The Tribunal considered paragraph 16(g) of GMP which states:

'16 In providing clinical care you must:

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.'

77. In relation to the removing of the stitches, the Tribunal accepted from the experts that this fell below the required professional standards, but not seriously so. It recognised that this procedure was minor and can be carried out by non-professionals in a variety of settings, and that the risk of infection or complication was minimal. The Tribunal considered however, that as Mr Steer was in a personal relationship with Patient A at the time, he had breached paragraph 16(g) of GMP. In the circumstances however, it decided that his actions did not represent a serious departure from the professional standards required of him. The Tribunal concluded therefore that Mr Steer's actions amounted to misconduct but not serious misconduct. The Tribunal considered whether this failure should be considered as part of a course of conduct but decided that it was not similar in nature to the other allegations nor was it part of a pattern of behaviour.

78. In relation to Mr Steer's failure to record this consultation, the Tribunal again considered the joint expert report. Mr B thought that, taken together with the removal of the stitches, this fell below the standard required, but Professor C stated that on its own the failure to record a consultation in this context did not. The Tribunal concluded that this was a very minor procedure and failing to record it did not therefore meet the threshold for misconduct. The Tribunal considered whether this failure should be considered as part of a course of conduct but decided that it was not similar in nature to the other allegations nor was it part of a pattern of behaviour and did not of itself reach the threshold to constitute misconduct.

<u>Paragraphs 7 – 12</u>

79. The Tribunal reminded itself of the facts that had been alleged in paragraph 7-12 of the Allegation. Mr Steer had admitted that he filled out his appraisal form and that he failed to declare that he was the subject of an open GMC investigation following on from Patient A's complaint, and implied that Dr E had resolved the complaint by writing *'Dr* E *helped to resolve this.'*

80. The Tribunal had accepted the evidence given by Ms D who set out in detail the contact that she had with Mr Steer about the investigation. It also accepted from Dr E that he had not helped to resolve the complaint, nor had he told Mr Steer that he had done so. The Tribunal had decided that Mr Steer's actions were dishonest in both respects. It had not accepted Mr Steer's explanations that this was simply a '*lack of care and attention to detail',* and that he had not heard from the GMC and mistakenly thought that was the end of the matter. It did not accept the assertion made by Mr Steer during his impairment submissions that these actions were not intentional and were just a result of not ticking the right boxes on the form and that he had only *'been very stupid.'*

81. The Tribunal decided that Mr Steer's actions represented a serious departure from a number of paragraphs of GMP, namely paragraphs 1, 65, 68, 71(a) and 71 (b). These state:

> '*1* *Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues are honest and trustworthy, and act with integrity and within the law.*
>
> …
>
> *65* *You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.*
>
> …
>
> *68* *You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.'*
>
> …
>
> *71* *You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.*
>
> *a* *You must take reasonable steps to check the information is correct.*
>
> *b* *You must not deliberately leave out relevant information'*

82. The Tribunal determined that matters of dishonesty are serious, and concluded that fellow practitioners could find such dishonesty '*deplorable,'* and '*disgraceful.'*

83. The Tribunal therefore considered that Mr Steer's conduct in relation to both aspects of dishonesty taken separately and together were a serious departure from the professional

standards required of members of the medical profession. They had the potential to bring the medical profession into disrepute and undermine public confidence.

84. The Tribunal concluded therefore that both Mr Steer's dishonest entries on the appraisal form amounted to serious professional misconduct.

Impairment by reason of misconduct

85. Having found that Mr Steer's conduct amounted to serious misconduct (save for paragraph 6), the Tribunal then went on to consider whether his fitness to practice is currently impaired.

86. The Tribunal decided that the features set out in the *Grant* case were all engaged. Mr Steer's misconduct included aspects of clinical malpractice, sexual misconduct, and dishonesty, all of which brought the profession into disrepute, and breached the fundamental tenets of the profession. Mr Steer had put Patient A at risk of unwarranted harm during the operation on 19 December 2015 and had acted dishonestly when filling out the appraisal form in March 2021.

87. The Tribunal therefore carefully analysed whether Mr Steer's conduct was remediable, whether it had been remedied and whether there was any likelihood of repetition.

88. The Tribunal firstly considered whether Mr Steer's misconduct was remediable. It recognised that dishonesty and sexual misconduct is especially difficult to remediate because they go to a person's character. It decided however, on balance, that Mr Steer's misconduct could be remedied. His clinical performance could be improved by further research and training. The dishonesty and sexual misconduct could be remedied if Mr Steer were able to demonstrate full insight, remediation, and provide convincing evidence of his plans to prevent this behaviour in the future.

89. In determining whether Mr Steer had remediated his conduct, the Tribunal therefore considered the level of insight evidenced. It took into account the fact that Mr Steer had engaged with the Tribunal process at this stage of the hearing, and it had regard to his Reflections document.

90. The Tribunal noted that Mr Steer had acknowledged the Tribunal's findings and said that he understood the gravity and importance of them. He expressed '*deep regret for any actions or omissions that have led to this outcome,'* and said that the decision had '*prompted significant reflection on my part.'* Mr Steer apologised to Patient A when he gave his submissions to the Tribunal and wished her well for the future.

91. In relation to the clinical misconduct, Mr Steer accepted that the consent form was inadequate, but he tried to describe again why he had conducted the procedure. In his submissions to the Tribunal, however, he demonstrated that he had reflected. He said that he

had heard Mr B's view and conceded that in retrospect maybe the procedure was not indicated.

92. Mr Steer continued to deny the sexual misconduct, accepting only that he had crossed professional boundaries in allowing Patient A to come to his home in order to care for him. He denied again that he was present at the operation in February 2017, restating that the operation note was wrong.

93. Mr Steer continued to deny that he had been dishonest when filling out the appraisal form, reiterating that it was not intentional, and it was simply an error on the form and a misunderstanding between him and Dr E.

94. Mr Steer had denied the majority of the Allegation at the facts stage. The Tribunal was therefore mindful of the case of *Sawati* and the fact that a doctor has the right to defend himself. However, Mr Steer's continued denials in his Reflections document and during his submissions to the Tribunal at this impairment stage meant that he struggled to demonstrate evidence of insight, or that he understood the seriousness of the misconduct allegations that he was facing. The sentiments of regret and the apology to Patient A came very late having only been articulated in his impairment submissions, with the conduct having taken place between 2015 and 2021. Up until these submissions, Mr Steer had maintained that Patient A had edited WhatsApp messages and he said in the facts stage *'she decided to set me up'*. There was no evidence that Mr Steer had properly understood the potential impact on Patient A or on public confidence in the medical profession.

95. The Tribunal concluded therefore that Mr Steer had demonstrated very limited insight, which was only articulated in general terms. He had demonstrated some developing insight into his clinical misconduct, but very little in relation to the specific allegations of sexual misconduct or dishonesty.

96. The Tribunal then went onto consider the steps that Mr Steer had taken to remediate his actions. It accepted that Mr Steer had taken some steps to remediate his clinical misconduct. He had been keeping up to date with the research on endometriosis and the NICE and RCOG Guidelines and was aware of the use of the new drug, Relugolix CT. Mr Steer had also considered the guidelines on consent and had got copies of the new forms that he said he would use in the future. He had also undertaken a 30 minute Consent Course in May 2021. He had also conducted a Consent Audit relating to other patients he had treated, to check whether the consent issues were being correctly addressed.

97. The Tribunal considered whether Mr Steer had taken steps to remediate the sexual misconduct. It noted that he had taken a Professional Boundaries Course. However, the course was four years ago in November 2021 and was only 2 hours in duration. Mr Steer had not provided any reflections on that course, nor set out any learning from it.

98. The Tribunal considered whether Mr Steer had taken steps to remediate his dishonest actions. It noted in his Reflections document that Mr Steer said he had partially completed a

Probity and Ethics Course, which he intends to finish. Again, he did not provide any evidence of any learning from this.

99. The Tribunal was aware that Mr Steer had not now worked for 4 years, but he said that he would be willing to have a mentor to help him to understand and address his conduct in the future.

100. The Tribunal decided that Mr Steer had demonstrated that he had made some efforts to remediate his clinical misconduct, but very little evidence that he had addressed the sexual misconduct or dishonesty.

101. The Tribunal then went onto to consider the risk of repetition in Mr Steer's case. It took into account the fact that Mr Steer was of good character, and a senior consultant with many years of experience working in both the NHS and the private sector. He described that his work as a doctor had been his *'whole life'* and that he would '*dearly love'* to work for the NHS again. in his Reflections document he stated:

> *'I would also like to reaffirm my dedication to the medical profession and to the patients I serve. I am willing to undertake any necessary remedial actions or professional development to address the concerns raised and to ensure that my practice remains safe, effective, and in line with the standards expected of a registered medical practitioner.'*

102. The Tribunal took into account the two testimonials that it had received from previous work colleagues, and a character reference from an ex-patient. It gave them limited weight, even though they were now four years old, and also did not address the detail of the allegations that Mr Steer was facing.

> Ms G, a Consultant Obstetrician & Gynaecologist, said:
>
> *'I have always appreciated his honesty and his continued encouragement of all clinical staff including myself which has allowed me to often seek professional advice from him and discuss clinical matters.*
>
> *Whilst working in the O & G department with the other doctors, midwives, healthcare assistants and clerical staff he has always been a dependable and committed team member. He is also a very skilled surgeon. On many occasions I have heard first-hand the praise and gratitude of his quality of care from patients.'*
>
> Mr H, a Gastrointestinal, Bariatric & Laparoscopic Specialist said:
>
> *'I found Mr Steer pleasant, capable of doing his job a good colleague, cares about his patients and did respond when we needed him for an urgent Gynaecology opinion. L am not aware of any conflict between himself and any other colleague or member of staff. The patients that I met who were under shared care have always liked Mr Steer and followed his advice'.*

Ms I, ex patient, said:

'I have known Mr Steer for such a long time and feel totally comfortable and safe during the scans and do not feel that I require a chaperone. However, Mr Steer would always get out of his room and request for a nurse to be present during the scans'.

103. The Tribunal accepted that Mr Steer had been a committed and experienced doctor and was of good character. The testimonials and character reference from Ms G, Mr H, and Ms I demonstrate that they held him in high regard in terms of his clinical skill, patient care, and team working. However, the Tribunal was concerned about the lack of insight and remediation that Mr Steer had shown. It had decided that he had demonstrated some developing insight and remediation in relation to his clinical misconduct, but very little in terms of sexual misconduct and dishonesty. It therefore decided that there was an ongoing risk of repetition in Mr Steer's case.

104. The Tribunal reminded itself that all four features set out in *Grant* were engaged in this case and determined that, due to an ongoing risk of repetition, they remained engaged as of today. Mr Steer's actions also represented a departure from GMP. It considered the overriding purpose of the overarching objective. It decided that a finding of impairment of Mr Steer's fitness to practise was necessary in order to protect, promote and maintain the health, safety, and wellbeing of the public, maintain public confidence in the profession and to promote and maintain proper professional standards and conduct for members of the profession.

105. The Tribunal was reminded of the comments made by Cox J in the case of *Grant* which reads:

'74. …. In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

106. The Tribunal concluded that a finding of impaired fitness to practise was necessary and that a member of the public would be shocked if it were not made.

107. The Tribunal therefore determined that Mr Steer's fitness to practise is impaired by reason of his misconduct.

Determination on Sanction - 24/04/2025

1. Having determined that Dr Steer's 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

2. The Tribunal took into account the evidence it received during the facts and impairment stages of the hearing. It had already determined that Mr Steer's fitness to practise was currently impaired due to his clinical malpractice, sexual misconduct and dishonesty.

3. The GMC did not provide any further evidence at this sanctions stage. Mr Steer did not give oral evidence, but he did provide some further documents relating to the treatment of endometriosis which the Tribunal noted.

Submissions on Sanction

For the GMC

4. Mr Rigby reminded the Tribunal that sanction was a matter for the Tribunal's own judgment. He said that he did, however, wish to address the Tribunal and he referred it to the decisions it had made at the facts and the impairment stages. He said that he did not want to rehearse the findings but pointed out that the Tribunal had found serious misconduct in many respects and in different areas. He said that Mr Steer's conduct was so serious that only a serious sanction was appropriate.

5. Mr Rigby drew that Tribunal's attention to the fact that, at paragraphs 85 and 86 of its impairment determination, it stated that all four features of the guidance followed in the *Grant* case were engaged. He said that the Tribunal had found that Mr Steer had breached the fundamental tenets of the profession, and a number of paragraphs of GMP. He pointed out that this related to his misconduct in relation to clinical malpractice, sexual misconduct and dishonesty. He submitted that, with the overarching objective in mind, this case demanded a very serious sanction, more serious than suspension.

6. Mr Rigby then took the Tribunal through the sections of the SG that he felt were relevant. He firstly referred to the section headed *'Abuse of professional position'*, comprising paragraph 142-146. He said that trust is a foundation of the doctor-patient relationship. He said that paragraph 143 sets out that doctors must not use their professional position to pursue a sexual or improper emotional relationship, which is what Mr Steer had done. He asked the Tribunal to consider that Patient A was vulnerable, because she was a patient and only XXX years of age at the time. She was a junior member of the team with Mr Steer. She was suffering from endometriosis and had been for some while and was desperate for medical help. He said that her vulnerability could be seen as an aggravating factor.

7. Mr Rigby took the Tribunal to the section headed *'predatory behaviour'* at paragraphs 147-148, pointing out that Mr Steer had made inappropriate use of a social networking site

to approach Patient A outside the doctor- patient relationship. Mr Rigby referred to the section headed *'sexual misconduct'* at paragraphs 149-150, explaining that sexual misconduct with patients seriously undermines public trust in the profession, and that it is particularly serious where there is an abuse of special position of trust a doctor occupies. He said that Mr Steer had abused his professional position and that this was so serious that erasure was appropriate.

8. Mr Rigby said therefore, that the sexual misconduct on its own was sufficient for the Tribunal to consider erasure, but that there was also the dishonesty and clinical malpractice to consider too.

9. Mr Rigby then addressed the Tribunal on erasure, which he said was covered in the SG at paragraphs 107-111. He said that erasure may be appropriate even if a doctor does not present a risk to public safety, in order to maintain public confidence in the profession. He referred to the list of factors set out at paragraph 109 (a)-(g) which may indicate that erasure is appropriate. He said that there had been a series of breaches of and a deliberate disregard for a number of paragraphs of GMP. He said that Mr Steer's behaviour was difficult to remediate. He said that there had been a breach of trust and also acts of dishonesty. He submitted that Mr Steer had shown a persistent lack of insight into the seriousness of his actions and their consequences.

10. Mr Rigby said that it is sometimes argued that erasing the name of an able and willing doctor from the medical register is a loss to the public because they cannot provide a service any longer. He said that this argument is not justified in the case of Mr Steer.

11. In summary, Mr Rigby stated that a number of features of this case indicated that the appropriate course of action was that of erasure.

Mr Steer

12. Mr Steer addressed the Tribunal in relation to the allegations of dishonesty first. He said that he had no intention of being dishonest and accepted that honesty was a main characteristic that the public expects in a doctor. He said that he would not do it again. He explained that he was exhausted when he filled the appraisal form in because of the extra hours he had been working during the COVID-19 pandemic. He said that, in mitigation, when he found out that he had 'ticked' the wrong box, he asked Dr E if he could resubmit it, because he knew it was wrong, but Dr E told him it was too late. In retrospect, he stated that he should have checked with the GMC to see if the investigation had finished.

13. Mr Steer then addressed the operation that had taken place on 19 February 2017. He said that he did not do the operation and that was not in dispute. He said that he wished he was not there on that day, but Patient A had been admitted to the hospital the night before and he was then on call. He said that he could have sent her home, but that she was in pain, and he thought that would be unfair. He said he could have asked another consultant to come in to take over from him, but that would have been very difficult. He said that other consultants have family commitments and might not answer their phones when they are on

call. He said that he only popped into the theatre. He said that someone asking a consultant not to be involved in an operation was a *'once in a lifetime situation,'* and he could not see himself in such a situation again. It was a coincidence of events.

14. Mr Steer then addressed the relationship with Patient A. He said that he had no intention of *'getting involved'* with her. He agreed that he had overstepped the mark and had been too friendly. He said that he deeply regrets answering her messages and accepting her help after the XXX. He stated that it would not happen again, and that he has since been able to access NHS care but could not do at that time because he had been treated in XXX. He said he would never accept help from a patient again.

15. XXX

16. Mr Steer then addressed the operation that had taken place on 19 December 2015. Mr Steer said that he and his colleagues at King's College Hospital were motivated to alleviate women's pain, and that endometriosis can be excruciating, and affects a lot of women, as evidenced by the Hansard entry and House of Commons debate extracts that he had provided. He said that endometriosis is costing the state billions of pounds, and he could work with the Select Committee that was looking into this, and the RCOG. He said that it was not known to him that, outside of King's College Hospital, other consultants were managing the condition by medication, and that he and his colleagues were conducting multiple procedures. He knew now that there was the new medication and that is now preferred, but the Zoladex that was in use at the time did not work immediately and was only licenced for use for a six-month period. Mr Steer pointed out that he was being criticised for conducting the surgery two days after the consultation with Patient A, but said that, looking at the medical records it was evident that other consultants had done the same.

17. Mr Steer explained that he had not described what he had meant by the LUNA procedure, and that did not cut the utero sacral ligaments, and had no intention of doing so. He said that, in endometriosis cases, the uterine nerves are where the pain comes from, and he was trying to get rid of the pain when operating on Patient A. He said that later photographs showed that Patient A's utero sacral ligaments were still in place, and that the endometriosis had regrown.

18. Mr Steer said that he thought that the consent process was usually done in three stages, but he conceded that the potential complications should have been on the consent form. He said that he had now found the specific consent forms on the RCOG website, and he would use those in future, or cut and paste the risks and benefits onto the forms that any hospital he might work in would use.

19. Mr Steer said that he been working in medical care since 1982, and he had never intended to do anything wrong. He had worked hard all his life. He said that he was distraught and felt that he can still contribute. He pointed out that the testimonials and the character reference showed that he could still contribute too. He said that medicine was his life, and that it had been taken away from him. He said that he had learned and reflected, and that not being able to work for four years had been a catastrophe. He expressed extreme

regret for the things that had happened and said that he had not meant to be a risk and certainly would not be a risk from now on.

20. Mr Steer pointed out that he had been suspended for a period of three and a half years now, and that he had time to consider and reflect. Going forward he would not be able to work in private practise. He would like to be involved with the endometriosis society, government committee and RCOG, rather than clinical practice, and he feels that he is still young enough to do something.

The relevant legal principles

21. The LQC gave the Tribunal legal advice, which is summarised below.

The Tribunal has found that Mr Steer's fitness to practice is currently impaired due to his misconduct. The Tribunal is reminded that the decision as to the appropriate sanction, if any, is a matter for the tribunal's own judgement, which must be made independently.

The Tribunal must have regard to the SG dated 5 February 2024, which, although not statutory, gives an authoritative steer. It is reminded that it must have regard to the aggravating and mitigating factors, and consider the least restrictive sanction first, and then move on, if needs be, to consider the other available options in ascending severity.

The Tribunal must bear in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest. The Tribunal should be mindful that this is a balancing exercise -weighing up what is in the public interest, as against the interest of Mr Steer.

Any sanction must be appropriate and proportionate. In the case of *Bolton v Law Society [1994] 1 WLR 512.*it was made clear that the reputation of the profession as a whole is more important than the fortunes of any individual member, even if the consequences may be deeply unfortunate for them.

The Tribunal is informed that it can again take into account Mr Steer's hitherto good character and the testimonials when making a determination on sanction. The Tribunal is aware that Mr Steer is facing a matter of dishonesty. Dishonesty is very serious, especially if it occurs in the context of a doctor's professional duties. In the case of *Nkomo v GMC [2019] EWHC 2625 (Admin)* at paragraph 35 it states:

'The starting point is that dishonesty by a doctor is almost always extremely serious. There are numerous cases which emphasise the importance of honesty and integrity in the medical profession, and they establish a number of general principles. Findings of dishonesty lie at the top end of the spectrum of gravity of misconduct….

Misconduct involving personal integrity that impacts on the reputation of the profession is harder to remediate than poor clinical performance…. In such cases, personal mitigation should be given limited weight, as the reputation of the profession is more important than the fortunes of an individual member…

The Tribunal should also be mindful that Mr Steer is facing a matter that the Tribunal has found was sexually motivated, which seriously undermines trust in the profession. However, there is no default rule. The nature and extent of dishonesty or sexually motivated conduct may be variable and must be evaluated on a case-by-case basis. The circumstances of the case must be carefully considered by the Tribunal, and it should look to see if there is, for example, compelling insight, or evidence that the behaviour is out of character. It should decide if the reputation of the medical profession is affected.

The Tribunal will be aware, again, of the overarching objective of the GMC set out in section 1 of the Medical Act 1983.

The Tribunal's Determination on Sanction

22. The Tribunal considered the LQC advice, and the submissions from both parties. It reminded itself of the facts that it had found proved, and noted the new evidence it had received at this stage of the proceedings.

23. The Tribunal determined that Mr Steer is facing a number of serious misconduct matters comprising clinical malpractice, sexual misconduct and dishonesty.

24. The Tribunal first identified what it considered to be the aggravating and mitigating factors in this case. It was mindful that it needed to consider and balance any such factors against the central aim of sanctions, which is to uphold the overarching objective.

Aggravating Factors

25. The Tribunal firstly considered paragraphs 50-59 of the SG, which sets out some of the aggravating factors that are likely to lead a Tribunal to consider more serious action.

26. The Tribunal determined that the diverse number of allegations that Mr Steer is facing is of itself an aggravating feature in this case, along with the corresponding numerous breaches of GMP.

27. The Tribunal considered the level of insight that Mr Steer had demonstrated, which is covered by the SG at paragraphs 51-53. It had concluded at the impairment stage that he had demonstrated very limited insight, which was only articulated in general terms. He had acknowledged the Tribunal's findings and said that he understood the gravity and importance of them. He expressed '*deep regret for any actions or omissions that have led to this outcome,'* and said that the decision had '*prompted significant reflection on my part.'* Mr Steer apologised to Patient A when he gave his submissions to the Tribunal.

28. The Tribunal had concluded however, that in more specific terms, Mr Steer had demonstrated very little insight in relation to the specific allegations of sexual misconduct or dishonesty, and some developing insight into his clinical misconduct. During the impairment stage, Mr Steer continued to deny the sexual misconduct, accepting only that he had crossed professional boundaries in allowing Patient A to come to his home in order to care for him. He denied again that he was present at the operation in February 2017, restating that the operation note was wrong. He continued to deny that he had been dishonest when filling out the appraisal form, reiterating that it was not intentional, and it was simply an error on the form and a misunderstanding between him and Dr E. The Tribunal noted that Mr Steer maintained his position during his sanction submissions, although there was some concession that his relationship with Patient A was improper.

29. The Tribunal decided therefore that the lack of insight in Mr Steer's case was an aggravating factor.

30. The Tribunal next considered the circumstances surrounding the events. It firstly considered the clinical malpractice. It noted a number of aggravating features. The Tribunal was concerned that Mr Steer had carried out a procedure that was not indicated, despite him being a senior and experienced consultant based in a teaching hospital. He had deliberately not followed NICE Guidelines and had not discussed or considered this with other colleagues. Patient A had not had the benefit of a fully informed consent process and so was not aware that Mr Steer was going to carry out a procedure that was outdated.

31. The Tribunal next considered the sexual misconduct. It seriously undermines public trust in the profession and noted that it is particularly serious in this case because there was an abuse of the special position of trust that a doctor occupies. Such behaviour could damage the trust between a doctor and their patient, and the trust of the public generally.

32. The Tribunal considered paragraph 55(d) of the SG which states that aggravating factors of misconduct might include an abuse of professional position, particularly where this involves vulnerable patients or predatory behaviour. It therefore considered paragraph 145 and 147 of the SG.

33. Paragraph 145 states that where a patient is particularly vulnerable there is an even greater duty on a doctor to safeguard the patient. It sets out the characteristics which might make a patient more vulnerable. Patient A did not fall within the definition in that section, but the Tribunal decided that there were some elements of vulnerability that were aggravating features of this case. Patient A was a gynaecological patient and was only XXX years of age at the start of the improper relationship. Mr Steer was a senior consultant, and she was a junior XXX. There was a notable age disparity. The Tribunal determined that there was a breach of trust and an abuse of power. It accepted that Patient A was an adult but concluded that it was Mr Steer's responsibility to maintain professional boundaries.

34. Paragraph 147 states that if a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a

patient, there is a significant risk to patient safety, and to public confidence. It states that more serious action is likely to be appropriate where there is evidence of inappropriate use of social networking sites to approach a patient outside the doctor-patient relationship. The Tribunal therefore considered the use of the WhatsApp messages in this case. It accepted that the use of WhatsApp was commonplace within the team at the hospital, but nevertheless decided that Mr Steer was using it inappropriately when pursuing the relationship with Patient A.

35. The Tribunal lastly considered the dishonesty. It recognised that dishonesty is very serious and can undermine public confidence in the profession. It was aware of the caselaw and accepted that dishonesty is difficult to remediate. It noted that the dishonesty in this case was within a professional setting, and that Mr Steer had failed to take reasonable steps to make sure that the appraisal form was accurate.

Mitigating Factors

36. The Tribunal then went on to consider the mitigating factors in this case. It noted that although there were a number of matters that Mr Steer was facing, they all involved one patient.

37. The Tribunal considered paragraphs 24-49 of the SG, which sets out some of the mitigating factors that the Tribunal may consider, while balancing these against the central aim of sanctions.

38. Again, the Tribunal considered the level of insight that Mr Steer had demonstrated, which is covered by the SG at paragraphs 25(a) as a potential mitigating factor. The Tribunal reminded itself that it had concluded at the impairment stage that he had demonstrated very limited insight, which was only articulated in general terms. He had acknowledged the Tribunal's findings, expressed regret, and apologised to Patient A in his impairment submissions.

39. The Tribunal took into account the fact that Mr Steer was of previous good character. He had been in the medical profession since 1982 and had no previous findings of impairment.

40. The Tribunal accepted that the misconduct spanned a period of time from 19 December 2015 to 10 March 2021. The Tribunal accepted therefore that there had been a lapse of time since the incidents occurred.

41. The Tribunal considered the steps that Mr Steer had taken to remediate the misconduct. He had partially remediated the clinical malpractice. The Tribunal accepted that Mr Steer had a passion and interest in the treatment of endometriosis and therefore had kept his knowledge up to date. There remained a concern, however, that there was no evidence that Mr Steer was currently up to date with his surgical skills. He offered to have a supervisor or mentor, and showed a willingness to remediate, but few steps had been taken in this regard. He had attended a Professional Boundaries course, and partly completed a

Probity and Ethics course, but there was no other evidence that Mr Steer had remediated the sexual misconduct or the dishonesty concerns in this case. The Tribunal determined that there was some very limited mitigation therefore when considering remediation.

42. The Tribunal accepted the two testimonials from work colleagues, and the character reference from the ex-patient. While noting that they were now four years old, and did not address the allegations, the Tribunal accepted that they demonstrated that Ms G, Mr H and Ms I held Mr Steer in high regard in terms of his clinical skill, patient care, and team working.

43. The Tribunal concluded that the mitigating factors had less weight than the aggravating factors. The Tribunal then balanced the aggravating and mitigating factors throughout its deliberations and went on to consider each sanction in order of ascending severity, starting with the least restrictive.

No action

44. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances.

45. The Tribunal was satisfied that there were no exceptional circumstances in Mr Steer's case which could justify it taking no action. Further the Tribunal considered that concluding the case by taking no action would be insufficient to protect the public interest and would not mark the seriousness of Mr Steer's misconduct.

Undertakings

46. No undertakings were submitted to the Tribunal.

Conditions

47. The Tribunal next considered whether it would be appropriate to impose conditions on Mr Steer's registration and took into account paragraphs 80- 84 of the SG. It bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. The Tribunal noted that conditions may be workable where a doctor has insight into their misconduct, is likely to comply with conditions, and where a doctor is likely to respond positively to remediation or retraining.

48. The Tribunal accepted that Mr Steer was willing to further remediate the misconduct, and would likely work under conditions, but it remained concerned about the very limited insight that Mr Steer had demonstrated.

49. The Tribunal noted that one aspect of this case related to clinical malpractice, and that it might have been possible to address Mr Steer's performance in this regard. However, the concerns in this case relate also to sexual misconduct and dishonesty, and these were serious allegations.

50. The Tribunal concluded that this was not a case in which conditions would sufficiently address the issues of the case, and did not consider that any would be workable or measurable.

51. The Tribunal also decided that conditions would not reflect the seriousness of Mr Steer's misconduct and would be insufficient to maintain public confidence in the profession and to promote and maintain proper standards of conduct.

Suspension

52. The Tribunal then went on to consider whether imposing a period of suspension on Mr Steer's registration would be sufficient to satisfy the statutory overarching objective.

53. The Tribunal took into account paragraphs 91-98 of the SG, which assists the Tribunal in deciding if a period of suspension is the appropriate sanction. It acknowledged that suspension has a deterrent effect and can be used as a signal to the doctor, the profession, and to the public about what is regarded as behaviour unbefitting a registered doctor.

54. The Tribunal considered the factors listed at paragraphs 97(a)-(g) of the SG, where suspension may be deemed appropriate. It accepted that there was no evidence of repetition of similar behaviour since the incidents. It noted that Mr Steer was willing to further remediate, and it therefore had no evidence that he was unwilling to engage, or that demonstrates that remediation is unlikely to be successful.

55. The Tribunal noted that there was a multiplicity of misconduct, and that sexual misconduct and dishonesty is difficult to remediate. It was aware of Mr Steer's continual denials, very limited insight and lack of remediation. It determined that there was a risk that Mr Steer's behaviour could be repeated if the lack of insight continued.

56. The Tribunal found at the impairment stage that Mr Steer had breached a number of the paragraphs of GMP and that the four features of the *Grant* case were engaged. Mr Steer's misconduct included aspects of clinical malpractice, sexual misconduct, and dishonesty, all of which brought the profession into disrepute, and breached the fundamental tenets of the profession. Mr Steer had put Patient A at risk of unwarranted harm during the operation on 19 December 2015 and had acted dishonestly when filling out the appraisal form in March 2021. Due to the very limited insight demonstrated, the Tribunal remained concerned that the features of *Grant* could be repeated in the future.

57. The Tribunal was of the view that a fellow professional would consider Mr Steer's behaviour to be wholly unacceptable. It also concluded that given the seriousness of the misconduct, a member of the public, aware of the full facts of the case, would be concerned if Mr Steer were allowed to remain on the medical register.

58. The Tribunal determined therefore that a period of suspension would not be sufficient to maintain the health and safety of patients, to promote and maintain public

confidence in the profession, nor promote and maintain proper professional standards and conduct for members of the profession. It decided therefore, that suspension was not sufficient to send a message to the profession and the wider public about the gravity of Mr Steer's misconduct.

59. The Tribunal concluded that in such circumstances, to impose a period of suspension, would not uphold the three limbs of the overarching objective.

Erasure

60. The Tribunal therefore went on to consider whether the sanction of erasure was appropriate and proportionate in this case and took into account the guidance in the SG. The Tribunal reminded itself again of its findings of fact and the aggravating and mitigating factors it had identified.

61. The Tribunal considered paragraph 109, which sets out a non-exhaustive list of factors that, if present, may indicate that erasure is appropriate. The Tribunal decided that the following factors were present in Mr Steer's case:

> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *…*
>
> *d Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').*
>
> *…*
>
> *h Dishonesty, especially where persistent and/or covered up (see guidance below at paragraphs 120–128).*
>
> *…*
>
> *j Persistent lack of insight into the seriousness of their actions or the consequences..'*

62. The Tribunal also considered paragraph 109(e), which states:

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

63. The Tribunal decided that there were some elements of vulnerability relating to Patient A that were aggravating features in this case.

64. The Tribunal then considered paragraph 108 of the SG which states:

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

65. The Tribunal decided that Mr Steer would not present a high risk to patient safety if he fully remediated his clinical malpractice. It considered that this could be possible for him to do this in the future. Mr Steer acknowledged that he had failed to obtain informed consent. Although he did not fully accept all the clinical failings, Mr Steer had accepted Mr B's opinion and said that he would in future advise medication rather than surgery if a similar circumstance presented itself.

66. The Tribunal was concerned however about the sexual misconduct. It noted that Mr Steer had abused his professional position as a senior consultant and used it to pursue an improper emotional and sexual relationship with a patient and junior work colleague. In some respects, Patient A was vulnerable at the time, and Mr Steer pursued her via the social networking platform, WhatsApp. The Tribunal was concerned that Mr Steer was a gynaecologist and that he would be treating female patients who were particularly vulnerable. He showed a blatant disregard for professional boundaries, which were his responsibility to set. He continues to demonstrate very little insight.

67. The Tribunal was also concerned about the subsequent dishonesty when Mr Steer filled out his appraisal form within the workplace. Again, there is very little insight.

68. The Tribunal determined that, because of the sexual misconduct and dishonesty, Mr Steer had brought the profession into disrepute and undermined public confidence in the profession. He had recklessly breached a number of the paragraphs in GMP. Given the very limited insight and remediation, the Tribunal could not be confident that he would not do so in the future.

69. The Tribunal decided that erasure is necessary in Mr Steer's case to protect, promote, and maintain the health, safety and well-being of the public, promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for members of that profession.

70. The Tribunal also concluded that a member of the public would be concerned if a sanction of erasure were not imposed for the range of misconduct found proved.

71. The Tribunal took into account the impact that this sanction will have upon Mr Steer. However, in all the circumstances the Tribunal concluded that his interests are outweighed

by the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and behaviour. The Tribunal concluded therefore that Mr Steer's misconduct was fundamentally incompatible with continued registration and that removal from the register is in the public interest.

72. The Tribunal therefore determined to erase Mr Steer's name from the Medical Register.

Determination on Immediate Order - 24/04/2025

1. Having determined to erase Mr Steer's name from the medical register, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order of suspension.

Submissions

2. On behalf of the GMC, Mr Rigby submitted that an immediate order should be imposed to cover the pending appeal period. He referred the Tribunal to paragraphs 172 – 178 of the SG applicable to when an immediate order may be appropriate. Mr Rigby added that the public would expect an immediate order to be imposed for the serious findings of misconduct in this case.

3. Mr Steer submitted that he was devastated by the Tribunal's decision to erase his name from the medical register, adding that perhaps he did not have sufficient testimonials. Mr Steer said that a 28 day gap would give him a chance to attend further courses, adding that he had attended a professional boundaries course. He alluded to his health saying that he provided evidence of that. Mr Steer requested the Tribunal to afford him the chance to practise again.

4. Mr Steer said that instead of giving up on people, he always went out of his way to be supportive and help patients. He said he just wanted a window of opportunity of the 28 days in order to demonstrate that he had done everything possible to remedy what had been found to be wrong, and he certainly had insight into the concerns because he knew the consequences are as they have become now.

5. Mr Steer said that the 28 days pending appeal would give him a chance to attend further courses and take remedial action. He reiterated that he had no intention of being dishonest when completing the appraisal form and that he made a mistake.

6. He said that the standard treatment for endometriosis, which he said can ignore a woman for up to ten years before a diagnosis, is not appropriate, and that he would consider providing medication to women in the future if he were allowed to practise. Mr Steer said that he would work with the RCOG to do everything possible in order to treat women and expedite their care so they can become active members of their family and society. He said that he could do something in his life and that his work in gynaecology was his purpose in life.

7. He said that he did have insight into the concerns arising from the matters in this case. He reminded the Tribunal that ten years had lapsed since some of these events and that he had no previous adverse history with the GMC, there had been no repetition of these matters and no concerns since these matters came to light. He said that this was just an unfortunate series of events.

8. Mr Steer said that he could no longer work in private practice because he did not have the insurance because of the misconduct allegations and that he did not have a NHS job to go to. He said that he would like to do some locum work or work with others on the treatment of endometriosis.

The Tribunal's Determination

9. The Tribunal took account of the submissions made by Mr Rigby and Mr Steer and had regard to its findings on impairment, and the specific basis upon which it had reached its determination on sanction. It had regard to paragraphs 172 to 178 of the SG. Paragraphs 172, 173 and 178 state:

> *'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…*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *….*
>
> *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.'*

10. The Tribunal determined that, given the seriousness with which it viewed Mr Steer's misconduct, and its findings on impairment and the sanction, it was in the public interest to suspend his registration with immediate effect for the protection of patients. It concluded that imposing an immediate order was necessary to protect members of the public and was in the public interest. The tribunal decided that an immediate order was also necessary to protect public confidence in the medical profession.

11. This means that Mr Steer's registration will be suspended from today. The substantive direction of erasure, as already announced, will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless he appeals in the

interim. If he does appeal, the immediate order will remain in force until the appeal has concluded.

12. The Tribunal revoked the interim order of suspension upon Mr Steer's registration with immediate effect.

13. That concludes the case.

Annex A - 10/02/2025

Application to Adjourn (IN PRVATE)

1. Dr Steer is neither present nor represented at this hearing.

Dr Steer's submissions

2. The Tribunal received a number of emails from Dr Steer in relation to his request for an adjournment. On 31 January 2025, the Tribunal received an email from Dr Steer, and 2 letters from XXX. The email – which is dated 30 January, requests an adjournment. XXX

3. Dr Steer also asserted in the email that the proceedings are unfair, because he cannot afford to fund expert witnesses or obtain legal advice. He explained that such experts could assist him in describing the XXX effects of his XXX injury, the provenance of the WhatsApp messages, and the appropriateness of the laparoscopic operation. Dr Steer also claimed that the GMC have rejected witness statements that would assist his defence, and refused to instruct a WhatsApp expert, or give him access to Patient A's medical records.

4. XXX

5. XXX

6. XXX

7. On 7 February at 2:05, the Tribunal received another email from Dr Steer stating that he was at home and still wanted to apply for an adjournment. He raised the issues again about the fact that he was unrepresented, but also stated that he had not had any contact with Special Counsel regarding the cross examination of Patient A. XXX.

8. On 10 February, Dr Steer confirmed that he wanted the application to adjourn to be considered in his absence and reiterated his concern about the lack of contact with Special Counsel.

GMC submissions

9. Mr Terence Rigby, Counsel, submitted a written response to Dr Steer's application to adjourn and made oral submissions. He opposed the application and pointed out that it had been made very shortly before the hearing, i.e. 30 January 2025. He explained that Patient A has been ready to give evidence on 3 occasions, (including evidence of a sexual nature) and it would be unfair to postpone her evidence yet further.

10. Mr Rigby set out the history of the case, explaining that the complaint had been made by Patient A on 3 June 2020, and then a further allegation arose in March 2021 in respect of his completion of an appraisal form. He explained that the present hearing has been listed

since 29 May 2024, and that the case had been listed twice before and adjourned at the request of Dr Steer. It was last listed on 11 October 2023 but was adjourned because XXX.

11. Mr Rigby explained that at the time the current hearing was being listed, Dr Steer had been represented, and that agreements had been made about the evidence and which witnesses should be called. It was not clear why he was no longer represented. An IT expert had been instructed by Dr Steer relating to the WhatsApp messages, and a clinical expert – Professor C – had signed a joint expert report with the GMC expert. Dr Steer had also made a statement setting out his case in respect of his clinical care of Patient A, and the allegations relating to the appraisal form. All that remained was for Dr Steer to respond to Patient A's allegations of an inappropriate and sexual relationship with her.

12. Mr Rigby stated that, since Dr Steer has been unrepresented, no further evidence has been served (save for the expert response to Dr Steer's statement), the Allegation has not been amended. The issues in the case are not complex. However, Mr Rigby stated that Dr Steer has failed to co-operate with the GMC in preparing the case for the hearing and agreeing the bundles of evidence. The GMC had prepared a draft defence bundle for him. He pointed out that it was all too common for doctors to be unrepresented, and there was caselaw that asserted that it was not a reason to adjourn.

13. Mr Rigby confirmed that Dr Steer's request for voluntary erasure was refused on 7 February 2025.

14. XXX

15. XXX

16. XXX

17. Mr Rigby addressed the specific issues that Dr Steer had raised about the fairness of the proceedings. He confirmed that the GMC had not accepted the evidence from two witnesses and had advised that it was up to Dr Steer to call them. XXX. He confirmed again that the WhatsApp messages were considered by an IT expert and submitted that this is now an issue for cross examination of Patient A, and for Dr Steer to give evidence. He submitted that the medical records of Patient A would not be relevant. He explained that Dr Steer's recent claims in relating to the clinical issues had been addressed by the GMC expert, and that Dr Steer can seek to permission to mention other clinical views when he gives his evidence.

18. Mr Rigby noted the recent issue that Dr Steer had raised about the lack of instructions with Special Counsel. (The Tribunal heard from Mr Mullin, the Special Counsel instructed by the MPTS to cross examine Patient A on Dr Steer's behalf. He explained that he did not have instructions from Dr Steer and was waiting to hear from him. He said that his details had been sent to Dr Steer, with a request to Dr Steer to consent to his contact details being sent to Mr Mullin, but so far as he was aware, this consent had not been received.) Mr Rigby stated that this issue was perhaps another example of Dr Steer thinking that the case would

not go ahead or not wanting it to go ahead. He had not agreed the evidence, nor the draft defence bundle either.

19. Mr Rigby explained that Dr Steer has been assisted by the GMC in the preparation of his case. Also, the MPTS has instructed Special Counsel to cross-examine Patient A. Further help, and adjustments could be considered if needed. He said that if the hearing were adjourned, there is no reason to believe that there would ever be a time when it could be heard. There is no suggestion that Dr Steer will be able to fund or otherwise obtain representation in the future.

20. In summary, Mr Rigby said that the evidence provided by Dr Steer is 'wholly inadequate' to demonstrate that there cannot be a fair hearing and the public interest requires the application for an adjournment to be rejected.

Tribunal's Approach

21. The Legally Qualified Chair (LQC) gave the following advice:

22. The decision as to whether the case can be adjourned is a matter for the Tribunal within its discretion. R29 of the Fitness to Practice Rules states that the Tribunal should

> *'Take into account all the circumstances, including any likely inconvenience to witnesses and the effect of delay on the fairness of the proceedings'*

23. The Tribunal is reminded that every doctor has a right to a fair trial. This means that he must have a reasonable opportunity to put his case.

24. The Tribunal should also note that a culture of adjournments is to be deprecated and would be contrary to the efficient delivery of regulation. The Tribunal is reminded that in *GMC v Adeogba [2016]* it was stated that

> *'the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance …fairness fully encompasses fairness to the affected medical practitioner (a feature of prime importance) but it also involves fairness to the GMC.'*

25. The Tribunal must be conscious that the discretion to proceed should be exercised with care and caution. When deciding whether to adjourn, the Tribunal must balance the objective to be fair and just to the doctor against the wider public interest. There is the need to deal with cases expeditiously on behalf of the public ie to have efficient progress of proceedings and proper management of resources. It should also bear in mind the inconvenience and stress on the witnesses and the effect of further delay on their memory. The Tribunal should also consider whether any adjournment would resolve the issue anyway and the likely length that would be needed.

26. Each case is decided on its own facts. The Tribunal will need therefore to look at the age, seriousness, history and case management of the case. There are a number of different matters that Dr Steer wishes the Tribunal to consider:

27. Dr Steer's request to adjourn the matter for consideration to be given to voluntary erasure was no longer relevant, as a decision had been made in that regard.

28. Dr Steer has asked that XXX be taken into account when considering his adjournment request. The Tribunal should note therefore that the onus is on the doctor to demonstrate that XXX or that it would be unfair to proceed. XXX. In the case of *Webberley v GMC [2022] 12 WLUK 209* a doctor's appeal against the finding of the Tribunal was dismissed. The court concluded that the Tribunal had acted reasonably in refusing the doctor's application to adjourn, as he had not discharged the burden demonstrating that he was unfit to participate in proceedings.

29. XXX

30. The Tribunal should note that Dr Steer has also requested an adjournment because of his perception of the unfairness of the proceedings, relating to his lack of funds to instruct experts, and be represented, and the way in which the GMC has prepared its case.

31. In the case of *Webberley,* the doctor stated that his financial status was hampering him in preparing for and being represented at the hearing. It was made clear in that case that it was a doctor's responsibility to engage with his hearing, and the GMC as his regulator, and lack of finances would not be a justification for postponing a hearing as many doctors would be able to avoid proceedings by not having adequate insurance or funding. In any event, the doctor had not produced evidence of his financial status to demonstrate his inability to obtain legal representation.

32. Dr Steer has raised some concerns about the GMC's handling of the case so far as the evidence is concerned, but the Tribunal must decide if the position would change were the matter to be adjourned. It is open to Dr Steer to request that such evidence be given little weight, and to have the witness cross examined should the hearing proceed.

33. The Tribunal is reminded that it should always be mindful of the overarching objective of the GMC set out in section 1 of the Medical Act 1983 (as amended) which requires the Tribunal to:

d. Protect, promote and maintain the health, safety and well-being of the public,

e. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

Tribunal's Decision on Application for Adjournment

34. The Tribunal took into account the request for an adjournment from Dr Steer, contained in the emails that he had sent, along with XXX that he produced. It also considered the written and oral submissions made by Mr Rigby, and the LQC advice.

35. The Tribunal noted that the decision as to whether to grant the adjournment was a matter for the Tribunal and its discretion.

36. The Tribunal was aware that the case had been fixed for a hearing on 3 occasions and had been adjourned on the last occasion due to XXX. It took into account that the witnesses were ready to give their evidence, and therefore the inconvenience and stress that it would cause were the matter to be adjourned.

37. The Tribunal also noted the age and seriousness of the case. Patient A had made the complaint in 2020, and the Allegation dates back to incidents in 2015. The matter related to issues of sexual impropriety, clinical performance, and a subsequent issue of dishonesty. The Tribunal decided that it was in the public interest to proceed as expeditiously as possible and noted that the request for voluntary erasure had been refused.

38. The Tribunal was concerned that the application to adjourn had been made very late, despite Dr Steer being advised as to his options, and how to progress this at the Case Management Pre-Hearing meeting in October 2024.

39. The Tribunal considered each of Dr Steer's specific points in turn. It firstly considered the issue relating to the fact that he was unrepresented and did not have funding.

40. The Tribunal was aware that Dr Steer had previously been represented in this case and that a lot of case preparation work had been done by his legal representatives. They had instructed counsel, and a clinical expert, and liaised with the GMC about the evidence. The Tribunal accepted the GMC submission that little had changed since Dr Steer had stopped being represented.

41. The Tribunal decided that a lack of funding or ability to be represented was not in itself a reason to adjourn a case. It accepted the GMC submission that many doctors are unrepresented. It noted that Dr Steer XXX and had been liaising with both the GMC and the Tribunal by email, with a full understanding of what was taking place. The Tribunal decided that it was a matter for Dr Steer whether he should obtain representation, and there was no suggestion from him that there would be any funds available in future, especially if he does not intend to return to medical practice.

42. The Tribunal secondly considered Dr Steer's perceived perceptions that the case was being handled unfairly by the GMC. He said, for example, that they would not accept two witnesses' statements, nor give him access to Patient A's medical records. The Tribunal took into account the GMC response to these issues: in essence, that which witnesses to call was a matter for Dr Steer and that he could make applications to admit their evidence to the Tribunal, and that the medical records of the patient were not relevant.

43. The Tribunal decided that issues of fairness and admissibility are a matter for the hearing process, and not a reason to adjourn the hearing in itself.

44. XXX

45. XXX

46. The Tribunal decided therefore that Dr Steer had not demonstrated that he was unable to participate in the proceedings. This was a case being held remotely, so Dr Steer could remain at home. He was liaising well with the Tribunal, and was able to read, type, email, and use a screen. The Tribunal decided that the case should not be adjourned because of XXX.

47. In his later two emails, Dr Steer raised a concern that he had not given instructions to Special Counsel. The Tribunal thought that this matter was unfortunate and may cause a short delay should the matter proceed with Dr Steer present. The Tribunal determined, however, that this was not a reason to adjourn the case to another date.

48. Bearing all the above in mind, and in summary, the Tribunal decided that it was in the public interest for this case to be heard and therefore the request for an adjournment is refused.

ANNEX B – 11/02/2025

Service and Proceeding in Absence (Rule 40) (IN PRIVATE)

1. Dr Steer was neither present nor represented at this hearing.

GMC Submissions

2. Mr Rigby explained that the GMC, under *R31* of the Rules, had to demonstrate that all reasonable efforts had been made to ensure that Dr Steer is aware of the hearing, so that the Tribunal may now hear the case. He said that this was an unusual case, because it was clear that Dr Steer knew of the hearing- he had been participating in it via email over the last 6 days.

3. Nevertheless, Mr Rigby stated that it was necessary for the GMC to prove that service had been effected, and it had sent therefore a bundle of documents to show that Dr Steer had received notification of the hearing. He said that it was '*perfectly plain'* that everything had been done correctly, in the normal way. Relevant contact had been made and notice given.

4. Assuming that the Tribunal accepted service, Mr Rigby stated that the tribunal had a discretion to proceed which should be exercised judicially and that it should ensure that Dr Steer could receive a fair trial under Article 6 of the European Court of Human Rights.

5. Mr Rigby drew the tribunal's attention to the case of R *v Hayward, Jones, and Purvis (2001) QB 862 CA,* which, although a criminal case, was of assistance. He stated that it was modified by the regulatory case of *GMC v Adeogba [2016], EWCA Civ 162,* parts of which he quoted. Mr Rigby explained that a criminal court can enforce a defendant to attend, which the Tribunal cannot in the case of a doctor. *Adeogba* states that deciding to proceed in a criminal case is different to a decision that should be made under *R31,* because of the overriding objective under the Medical Act, and the need for

> *'the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance …fairness fully encompasses fairness to the affected medical practitioner (a feature of prime importance) but it also involves fairness to the GMC.'*

6. Mr Rigby stated that there was no good reason to not proceed, and that the background was the same as when the decision whether to adjourn was considered; this was the third time the case had been listed, Dr Steer had the benefit of some legal representation leading up to the earlier hearing dates, and little more preparation has since been needed.

7. Mr Rigby pointed out that Dr Steer was not at the same disadvantage as another doctor might be who had not had any legal representation at all. He said Dr Steer was a man of intellect, who could take part in the hearing, but was choosing not to. He had taken little part in the presentation of the case, agreeing a defence bundle, and arranging for his witnesses to attend, or asking that their evidence be read.

8. Mr Rigby said that the delay in this case was now substantial, with the incidents dating back to 2015 and reported in 2020. He said that the delay was partly Dr Steer's fault, and that a witness of fact would be disadvantaged if the matter were delayed further, and the expert witness deserved consideration too. Mr Rigby said that there would have to be a very good reason therefore to justify not continuing.

9. XXX. Bearing in mind the way in which the Tribunal had considered Dr Steer's case so far, Mr Rigby said that he was sure that it would ensure a fair trial, and that accommodation could be made. If he attended, Dr Steer would have the benefit of Special Counsel, and if he continues to absent himself, the GMC's view was that such absence was now voluntary.

10. In summary, Mr Rigby stated that the hearing ought to proceed, and that if Dr Steer wished to attend at any stage he could do so.

Dr Steer's submissions

11. The Tribunal took into account the submissions that Dr Steer made in his earlier application to adjourn, along with the XXX that he had furnished the Tribunal with.

12. Dr Steer was invited, following the Tribunal's decision to refuse his application for adjournment, to provide any submissions on proceeding in absence, should he not be able to attend the hearing. In his email response to the MPTS, dated 10 February 2025, timed at 15:14, Dr Steer stated:

> *'XXX*
> *It surely isn't legally valid to continue in my absence ?'*

Tribunal's Approach

13. The Tribunal accepted the Legal Qualified Chair's advice as follows:

> 'In order to proceed in absence, the Tribunal must be satisfied that Dr Steer has been served with a notice of the hearing in accordance with R40 of the Rules, which sets out the practicalities of service. The doctor should have been served notice by either ordinary post, or electronic means – using the addresses notified to the GMC. And there must be evidence that the notice has been served. The MPTS must ensure that a doctor is informed of the date, time, and venue of the hearing, and his right to be legally represented and attend the hearing. They should tell him of the Tribunal's powers of disposal, and of the Tribunal's power under R31 to proceed in their absence. The doctor must have 28 days' notice.
>
> In essence the Tribunal needs to determine that Dr Steer was aware of the detail and date of the hearing.
>
> If the Tribunal is satisfied of service, then, it is entitled to proceed under R31, but it has the discretion in deciding whether it would be appropriate to proceed in the doctor's absence. The alternative is to adjourn the case. The Tribunal must be conscious that the discretion to proceed should be exercised with care and caution. The Tribunal must consider all material circumstances including for example, why the doctor is absent, and whether his absence is voluntary, ie whether he has waived his right to be present and whether there is a risk of the Tribunal reaching an improper conclusion, and the extent of the disadvantage to the doctor. It is incumbent on the Tribunal to ensure that the doctor has a fair hearing should it decide to proceed in his absence.
>
> In the case of *Hayward, Jones, and Purvis*, LJ Rose listed 6 principles to consider. This is a criminal case, but is a useful start point:
>
> a. A defendant in general has the right to attend his trial and a right to be represented.

b. Those rights can be waived- by for example by a defendant deliberately absenting himself, withdrawing his instructions or being obstructive in the hearing.
c. It is the tribunal that has a discretion to decide whether to proceed in the defendant's absence.
d. That discretion should be exercised with great care, and it is only in rare and exceptional circumstances where it would proceed in the absence of the defendant.
e. Fairness to the defendant is of prime importance but fairness to the prosecution must also be considered. When considering these issues such as the length of the adjournment, the reason for the absence, whether there are witness etc, should all be taken into account.
f. If the tribunal is to proceed in the defendant's absence, then it is incumbent upon us to make sure that the defendant has a fair hearing.

The Tribunal is reminded that in the *Adeogba* case, which is a regulatory case, it adopted the *Jones* case, but made some distinctions, explaining that proceeding with a criminal trial was different to making a decision under R31 particularly because of the overriding objective of the GMC and MPTS, and the fact that a defendant can be forced to attend where a doctor cannot.

The Tribunal should again take into account the reason why Dr Steer has not so far attended, and therefore it should consider again the XXX that Dr Steer has forwarded, and the information that it has received since 3 February. It should also still be mindful of the cases of *Webberley* and *Hayat,* (mentioned above) which set out what is required in XXX before the Tribunal.

The issue of deciding whether to proceed in the absence was also considered in *Lovett v HCPC, [2018] EWHC 1024 (Admin)* where the High Court held that proceedings could continue, even if a practitioner were absent for XXX as long as it was fair to do so.

Again, each case is to be decided on its facts. As it did in the application to adjourn, the Tribunal will need therefore to look at the age, seriousness, history and case management of the case, and of course its overriding objective under the Medical Act.'

Proceeding in Absence

14. The Tribunal took into account the submissions made by the GMC, and it considered again Dr Steer's request for an adjournment and the medical evidence provided.

15. The Tribunal firstly satisfied itself with regards to service. The Tribunal read the bundle of documents sent by the GMC. These showed that Dr Steer's email address that he had been making contact from was the same one which was on the GMC register. It noted that the GMC had written to Dr Steer at that email address on 2 December 2024, with the *R15* Notice of Allegation. This was followed up by a letter sent to the address on the GMC

register and the Royal Mail had confirmed proof of delivery. The Tribunal also noted that the MPTS had written to Dr Steer on 16 December 2024 by email, and then on 18 December by post, outlining the date of the hearing and all the other practical issues set out and required in *R15.* Again, the Royal Mail confirmed proof of service.

16. The Tribunal decided that it was clear that Dr Steer was aware of this hearing, which should have started on 3 February 2025, because he had been regularly emailing the MPTS since that date.

17. The Tribunal was satisfied that there had been the appropriate service in this case, and so it then moved on to consider whether to use its discretion to proceed in Dr Steer's absence, should he continue not to attend. It bore in mind the case law of *Jones* and *Adeogba.*

18. The Tribunal was conscious that the discretion to proceed in the absence of a doctor should be exercised with the utmost care and caution, balancing the interests of the doctor with the wider public interest.

19. The Tribunal again considered the reason that Dr Steer was putting forward as to why he was not at the hearing. XXX. The Tribunal noted that Dr Steer had been participating in the hearing and had been able to read, type and respond to queries. It saw no reason why he could not participate, and it determined that he had been given every opportunity to do so.

20. The Tribunal took into account the objective to uphold public confidence, and the commentary in *Adeogba,* and considered that it had a duty to effectively and expeditiously progress this case. The incidents now dated back to 2015, having been reported in 2020. The Allegation involves serious matters of sexual impropriety, dishonesty and clinical performance. Stress and further inconvenience would be caused to the witnesses in the case, especially Patient A. The case had been listed for hearing twice before, and the witnesses were ready to give their evidence again. The Tribunal decided that fairness goes both ways, and that it would be unfair to the witnesses and to the GMC not now to make progress.

21. The Tribunal was satisfied, given the seriousness of the issues raised in this case, that it was appropriate to proceed in Dr Steer's absence should he choose not to attend. It concluded that no useful purpose would be served by adjourning to a later date. In accordance with *R31,* the Tribunal determined to proceed in Dr Steer's absence.