



Neutral Citation Number: [2021] EWCA Civ 763

Case No: C1/2020/1702

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT
THE HONOURABLE MRS JUSTICE FOSTER
[2020] EWHC 2518 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20/05/2021

Before :

LORD JUSTICE NEWEY
LORD JUSTICE PHILLIPS
and
LADY JUSTICE ANDREWS

Between :

DR RAIED HARIS
- and -
THE GENERAL MEDICAL COUNCIL

Appellant

Respondent

James Leonard (instructed by **Radcliffes LeBrasseur LLP**) for the **Appellant**
Jenni Richards QC (instructed by **GMC Legal**) for the **Respondent**

Hearing date: 13 May 2021

Approved Judgment

Lady Justice Andrews:

Introduction

1. The appellant, Dr Haris, qualified as a doctor in 2008 and as a GP in August 2014. In 2017, two female patients made complaints against him that he had undertaken non-clinically indicated intimate examinations of them without their informed consent (and without wearing gloves). The incidents occurred in completely different locations within a couple of weeks of each other, the first whilst he was working as a locum GP in the out-of-hours service in a town in Lancashire on 23 February 2017, and the other whilst he was working in the Minor Injuries Unit at a Yorkshire hospital on 5 March 2017. There was a striking similarity between the behaviour described by each of the complainants. There was no question of collusion.
2. Dr Haris strongly denied that the inappropriate behaviour which the patients described had taken place; but the Medical Practitioners Tribunal (“MPT”) believed their accounts of what happened and found that it did.
3. Despite finding that the acts complained of “could reasonably be perceived as overtly sexual”, the MPT found that the respondent (“the GMC”) had not proved on the balance of probabilities that Dr Haris’s conduct was sexually motivated. They did so after accepting the diagnosis of a consultant forensic psychiatrist, Dr Vandenebee, that Dr Haris suffered from Asperger’s syndrome, and his evidence that there was a pervasive pattern of abnormalities in the way in which Dr Haris interacted with others. They found, at paragraph [112] of their fact-finding (Stage 1) determination, that Dr Haris had “provided a potential explanation that, if he did such actions, they were not for his own sexual gratification, since he had and has no interest in sexual matters” and that “the weight of the evidence on this point was in the doctor’s favour.”
4. Having subsequently determined that, even though the actions were not sexually motivated, Dr Haris’s fitness to practice was impaired, the MPT decided to impose conditions upon his registration for a period of 12 months. Quite understandably, the GMC appealed under section 40A of the Medical Act 1983. Foster J allowed the appeal, [2020] EWHC 2518 (Admin), finding that the only rational conclusion to be drawn from the facts found by the MPT was that the motivation for the touching was sexual. She substituted her own finding to that effect.
5. Foster J also accepted the submissions made on behalf of the GMC that the material filed after the MPT had determined which allegations were proved, did not demonstrate that Dr Haris understood the gravity of his behaviour. She found at [55] that his responses could not be described as an insightful response to the factual findings, but rather, were inconsistent with them, and therefore that it was not within the bounds of reasonable findings in the circumstances of this case for the MPT to decide as they did with regard to insight and remediation.
6. The sanction imposed on Dr Haris was plainly wrong because, even absent a finding of sexual motivation behind his actions, they constituted serious and distressing, uninvited intimate intrusion upon the two patients. The Judge therefore quashed the MPT’s findings as to remediation, risk and sanction, and remitted the matter of sanction to the MPT. Those aspects of her order are not appealed.

7. Dr Haris was granted permission to appeal to this Court on the sole ground that Foster J was wrong to consider that the only rational conclusion to be drawn was that the motivation for the touching was sexual. Therefore, the matter of sanction will fall to be reconsidered by the MPT come what may, and the Judge's findings from [52] onwards of her judgment are not directly relevant to this appeal. However, the question whether there was or was not a sexual motivation behind Dr Haris' actions will naturally have some bearing on the issues of risk and remediation and the public interest in that context. Unsurprisingly, therefore, the sanctions hearing has been stayed pending the determination of this appeal.
8. Given the Judge's finding of irrationality and the gravity of the potential consequences for Dr Haris, it was right that he should be given the opportunity to challenge it on appeal to this Court and to seek to persuade us that there was some other rational inference that could be drawn from the facts found, particularly in the light of the evidence of Dr Vandenabeele. However, for the reasons which I shall explain, and despite the attractive way in which Mr Leonard presented the oral arguments on behalf of Dr Haris, I cannot fault the Judge in her approach or her conclusions, with which I respectfully agree.

The law

9. It is unnecessary to set out the legal framework, which the Judge describes accurately at [27]-[29] of the judgment. She also set out the relevant legal principles, with relevant extracts from the leading cases at [30]-[35]. For present purposes the following summary should suffice.
10. The distinction between the approach to be taken by the High Court on an appeal by the GMC under s.40A (which is by way of review) and on an appeal by the medical practitioner under s.40 of the 1983 Act (which is by way of re-hearing) was very recently considered by this Court in the context of two appeals by doctors under s.40 against sanctions imposed on them by the MPT: *Sastry and Okpara v GMC* [2021] EWCA Civ 623. However, that distinction does not affect the way in which we should approach this appeal.
11. At [108], Nicola Davies LJ, delivering the judgment of the Court, expressly endorsed the approach taken by the Court of Appeal in *Bawa-Garba v GMC* [2019] 1 WLR 1929 as being appropriate to the review jurisdiction applicable in s.40A appeals. In *Bawa-Garba* (referred to by Foster J at [33]) it was confirmed that if the decision under challenge is an evaluative one, (as it is in the present case) the appellate court may interfere where there is an error of principle or if the decision fell outside the bounds of what the adjudicative body could properly and reasonably decide.
12. That was the approach which Foster J took. She also directed herself by reference to the principles set out by the Divisional Court in *GMC v Jagjivan* [2017] 1 WLR 4438 at [40], which she set out in full in her judgment at [30]-[31].
13. *Jagjivan* was also an appeal under s.40A. Sharp LJ reiterated that the test for allowing such an appeal under CPR Pt 52 is that the decision of the MPT is "clearly wrong." She said that whilst the appeal court must be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of witnesses who the Tribunal, unlike the appellate court,

has had the advantage of seeing and hearing, it is under less of a disadvantage when the question is what inferences are to be drawn from specific facts:

“The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Pt 52.11(4).” [Now CPR Pt 52.21(4)].

14. One of Mr Leonard’s central submissions on this appeal was that the Judge failed to apply all the relevant principles in *Jagjivan*. The MPT’s finding that there was no sexual motivation was a finding of fact, and although that finding was necessarily made in consequence of drawing inferences from the evidence, Foster J nowhere acknowledged the advantage that the Tribunal had of seeing and hearing the witnesses (including Dr Haris himself), and the great care and attention that they paid to the evidence, lay and expert, concerning his professed lack of interest in sexual matters. Nor was there anything in the judgment to indicate that the Judge reminded herself of the need for extreme caution before disturbing findings based on that evidence.
15. Mr Leonard relied on Mostyn J’s observations in *Basson v GMC* [2018] EWHC 5050 (Admin) at [18]:

“I am prepared to accept that in a regulatory appeal the appellate challenge to a finding of fact derived from inference or deduction is less stringent than a challenge to a concrete finding of fact. Generally speaking, a finding of fact, whether one of a primary concrete nature or one made on the basis of inference or deduction, can only be challenged on appeal where it can be said that the finding is wholly contrary to the weight of the evidence or that there was some fault in the decision-making process that renders the finding unsafe.”

That passage was among a number from the judgment in *Basson* quoted by Foster J at [35]. *Basson* was an appeal under s.40, and thus proceeded by way of re-hearing, but what was said there is not inconsistent with *Bawa-Garba*.

16. I shall address these and the other criticisms of the Judge’s approach made by Mr Leonard after setting out the fact-findings made by the MPT from which the inferences were to be drawn.

Factual background

17. Following a fact-finding hearing in January 2019 at which Patient A, Patient B and Dr Haris were among the witnesses who gave oral evidence, and the complainants were subjected to sustained cross-examination by Dr Haris’s then counsel on the basis that their accounts were untrue, the MPT accepted the evidence of the complainants and rejected the appellant’s evidence. As Foster J observed, they did so in strong terms.

Patient A.

18. Patient A had attended the out of hours service complaining of bad stomach pains that had previously been considered gallstones. Her mother was in the consultation room, but sitting with her back to the examination. After Dr Haris had asked her to undo her trousers, which she did, he suddenly pulled down her underwear, exposing her pubic region, and began pressing just above her pubic area, at which point she said words to the effect of: “the pain isn’t there”. He replied that he was “checking for lumps” and

kept prodding with two fingers in the area. Then, without prior warning or explanation, Dr Haris, who was not wearing gloves, put a finger on each of the lips of her vagina and pulled them apart. He stared at her pubic area for a few moments, and then went back to prodding her stomach. Subsequently, as he leaned over her to conduct an examination of her left side, his pelvis made contact with her right side.

19. At the end of the consultation, the patient was visibly distressed. Her mother rang the Service Lead for the out of hours service on the following day to complain on Patient A's behalf.
20. In his immediate response to the complaint, in his witness statements and in his oral evidence Dr Haris denied the allegations of intimate touching, stating that they never occurred, and relied on his computerised consultation notes which were typed up more or less contemporaneously. The consultation notes made no mention of an intimate examination, as they should have done if one was carried out. Dr Haris stated that he carried out a normal abdominal examination. His counsel at the hearing (not Mr Leonard) made a submission, which the MPT rejected, that Patient A had made up the complaint to get her mother's attention.

Patient B

21. Patient B attended the A&E department of the hospital after suffering a fall. She was accompanied by her husband, who also gave evidence before the MPT. She had a lot of pain in her upper back, and a single bruise on one of her buttocks. After waiting for almost 4 hours, during which time she could not sit down because of the severity of the pain, she was taken to a small consulting room. Dr Haris initially examined her back and her ribs whilst she was standing facing towards him. During that part of the examination it would have become apparent that she was not wearing a bra. He then asked her to turn around and, without any explanation of what he was doing, began to caress her buttocks. She had adjusted her underwear to reveal the bruise she had sustained in the fall, expecting him just to look at it. She tried to move his hand to the bruise, but he continued to caress her buttocks for some 10 to 15 seconds.
22. He then moved her underwear further across, inserted his finger between her legs from behind and touched and parted the lips of her vagina. He held his finger on her vagina for around 3 seconds. He then resumed his examination by moving his hand to her coccyx. He was not wearing gloves.
23. Throughout this part of the examination there was no independent chaperone and the MPT found that Dr Haris's handwritten notes of the consultation, which suggested that one was offered and declined, were wrong. They preferred the contrary evidence of Patient B, who they described as "dignified and impressive," and her husband, who was "an impressive witness". The husband, who was present in the consultation room, could not see what the doctor was doing when he examined his wife's lower half, because she was facing him and blocking his view. He gave evidence that his wife's face suddenly had a surprised expression, and he also corroborated her evidence that afterwards she whispered to him: "that was invasive".
24. After this part of the examination, Dr Haris asked Patient B to go with him to a different room, where there was a cubicle with a bed, and curtains round it. He asked her husband to leave, which he did. They were joined in the cubicle by a nurse who

held the curtains together. The doctor asked Patient B to stand up and pull up her top to just under her breasts. The nurse was standing behind the patient, in a position where she could not see what the doctor was doing. He put one hand on Patient B's top and with his right hand began fondling her left breast. The patient described this as "just groping". It was done with the full palm and lasted about 5 seconds. After that incident she made it clear to him that she was not prepared to let him touch her chest again. She became very upset and tearful, and anxious to leave the hospital.

25. Once outside the hospital, she told her husband what had happened. She seemed to be in shock. On the following day they telephoned the hospital to make a complaint and were advised that they could complain to the police, which they also did.
26. Dr Haris's handwritten records of the examination of Patient B were not all made immediately afterwards; some parts were written 2-3 hours later. He had conducted other consultations at the hospital that day after seeing Patient B. The MPT found that the handwritten records contained inaccuracies, including allegations relating to Patient B's mental health which were not borne out by her historic medical records. The notes specifically recorded that Dr Haris had not conducted an intimate examination nor a breast examination.
27. The MPT found that some of the explanations given by Dr Haris for his actions (on his account of the examinations) were contradictory, and did not make sense. They gave clear and cogent reasons for preferring the evidence of the two patients to that of Dr Haris and, to the extent that it conflicted with the evidence of Patient B, the evidence of the nurse who was present at the time of the breast fondling incident, whose recollection was found to be demonstrably unreliable. They pointed out the "virtually identical way" that both complainants said that Dr Haris had touched their vaginas, by parting the lips with his fingers. Each complainant had given a consistent account of what happened to her, both had extensive medical histories but had never made similar complaints against other doctors, and both "acquitted themselves well" in giving their evidence. Moreover, Patient B's account was substantially corroborated by the evidence of her husband.
28. Whilst the MPT did not expressly state that Dr Haris was lying, that was a matter of necessary implication from their rejection of his evidence where it directly conflicted with that of the two complainants. Mr Leonard rightly did not seek to suggest otherwise. The Tribunal made it clear whenever they found that a witness's memory was impaired or their recollection was unreliable.

The MPT's flawed approach to the issue of sexual motivation

29. As Mostyn J pointed out in *Basson* at [17] the state of a person's mind is not something that can be proved by direct observation, but can only be proved by inference or deduction from the surrounding evidence.
30. On the findings made by the MPT, there was:
 - i) Intimate skin to skin touching of the female sexual organs (and in the case of patient B, her buttocks and breast as well as her vagina);
 - ii) No clinical justification for that touching; and

iii) No other plausible reason for that touching.

Moreover, the person who did the touching was a fully qualified medical doctor who must have been aware that: (a) what he was touching were sexual organs (b) a record must be kept of any intimate touching of that nature in the context of a clinical consultation and (c) he should have obtained the patient's prior consent.

31. *Basson* was a case in which the finding was that the doctor had fleetingly touched the leg of a female patient when there was no clinical reason to do so, and made a comment about her wearing a short skirt. The MPT found that sexual motivation was proved, notwithstanding that (in contrast to the present case) it treated the doctor as a witness of honesty and accepted that he did not recall the incidents complained of. The doctor's appeal was dismissed on the basis that the finding was open to the tribunal on the evidence before it; indeed Mostyn J went so far as to say that it would have been arguably wrong for it to have reached any other conclusion.
32. Similarly in *Jagjivan* the MPT had accepted a female patient's account of how a cardiology registrar had made inappropriate suggestions to her as to how her heart rate could be raised, by pointing to her nipples and vagina and suggesting that she could put pressure on them to get excited; despite this, they did not find proved the allegation that the doctor's actions were sexually motivated. The Divisional Court reversed that finding on the basis that:

“... notwithstanding the fact that Dr Jagjivan had not been seen to have acted in any similar manner before and what Dr Jagjivan himself said about his sexuality and that he was not sexually attracted to patient A, *there could be no motivation other than a sexual one for making statements to a partially dressed patient about intimate body parts and the stimulation of her vagina.*” (Emphasis added).
33. In the present case, as in *Jagjivan*, the inference to be drawn as to the motivation from the doctor's behaviour alone, and the absence of clinical justification for it, was irresistible.
34. Despite this, the MPT appear to have persuaded themselves that it had not been proved by the GMC that it was more likely than not that the touching was carried out for Dr Haris's sexual gratification (indeed, they went further and found that it was *not* carried out for sexual gratification) because there was credible, unchallenged, evidence before them from his sister and a close friend that supported his own assertion that he had no interest in a sexual relationship, and unchallenged evidence that he had described himself as “asexual” to Dr Vandenabeele, which description was consistent with his diagnosis. The Tribunal said that they had “not speculated as to what [Dr Haris's] motivation could have been”.
35. Yet Dr Vandenabeele accepted in cross-examination that although it was possible for someone on the autistic spectrum to have no interest in sexual relationships, autistic spectrum disorder was not inconsistent with having sexual urges or sexual feelings. In other words, the diagnosis of Asperger's did not mean that Dr Haris was *incapable* of having a sexual motivation for acting as he did. There is no mention of that part of the psychiatrist's evidence in the MPT's determination.

36. Mr Leonard's key submission, to which I have referred earlier, that the Judge paid insufficient deference to the advantages enjoyed by the Tribunal as the finders of primary fact, and failed to approach the exercise of reviewing their findings with adequate caution, was directed at the evidence that the Tribunal accepted from Dr Haris's sister and friend, and from Dr Vandenabeele, an expert medical professional who was doing his best to assist the Tribunal and whose opinions they were entitled to accept. However, that criticism is demonstrably misplaced, because even if all that evidence were accepted as truthful and reliable, it still did not provide a more likely explanation for Dr Haris's behaviour than the obvious one. That no doubt explains why the cross-examination of Dr Vandenabeele was so short.
37. In reaching its conclusions at [112] the Tribunal ignored the fact that the best evidence as to Dr Haris's motivation was his behaviour. As a matter of common sense, when a patient presents with pain in the upper back in consequence of a fall, there is no reason whatsoever for a doctor to examine her vagina, or to fondle her buttocks or breast. The behaviour was not just capable of being reasonably perceived to be overtly sexual, it *was* overtly sexual, and there is no other way in which it could have been perceived. A doctor, of all people, would have known that.
38. Contrary to the suggestion in paragraph [112] of the determination that it provided a "potential explanation" for his behaviour, Dr Haris's assertion that he has no interest in sex, however much it might be supported by the observations of his behaviour made by friends and family, and however consistent it might be with his diagnosis, did not even begin to explain why he engaged in acts which were overtly sexual in the context of examining two different female patients.
39. To take an illustration given by my Lord, Phillips LJ, in the course of the hearing, if X is found as a fact to have loaded a gun, held it against someone's head and pulled the trigger, and the issue is whether when he did those things he intended to cause that person really serious injury or death, the fact-finding tribunal might well hear and accept entirely credible evidence from X himself and from X's family and friends that he has been a lifelong pacifist, is kind to children and animals, and abhors violence. However, that information will not assist the tribunal in determining what inference can be drawn as to his intention when he held the gun to the victim's head, let alone point to a positive conclusion that it is more likely than not that he had no intention to kill or seriously injure. Such a conclusion would be perverse. The MPT went through a similar flawed process of reasoning, and that is why they ended up making what Foster J rightly held to be a finding that was not reasonably open to them.
40. It is also of obvious significance that Dr Haris's defence was not "I touched them believing it to be clinically justified, though I now accept that belief to have been mistaken", nor (save in the case of the contact between his pelvis and Patient A's side) that any touching was accidental, but rather, "I did not touch them intimately, and they have made up these allegations." He also sought to rely on his clinical records of the two examinations as support for his denials. Contemporaneous or near-contemporaneous records are often regarded by fact-finding tribunals as more reliable than a witness's recollection, though in this case, and for good reason, they were not.
41. The MPT in this case never considered, let alone addressed the implications of their findings that the patients were telling the truth (and therefore the doctor was not) and that the records were inaccurate. Certainly there is no indication in the determination

that these matters were taken into account by the MPT when making the critical fact-finding that his actions were *not* sexually motivated. They did not stand back and properly consider the inferences that were naturally to be drawn from those additional relevant factors. Nor did they consider how they might impact on the credibility of his professed lack of interest in sex.

42. Therefore, nowhere in their Stage 1 determination does one find any consideration of why Dr Haris had given them an untruthful account and accused the two women patients of lying, and how any of these matters might affect the question of his motive. Nor did they consider whether, in the case of Patient B, forgetfulness, or confusion with a different examination carried out in the next 2-3 hours, was really the most plausible explanation for the creation of a medical record falsely stating that there were no examinations of the type that took place (by a doctor who knew at the time that a similar, truthful accusation had been made by Patient A, in respect of whom he had not made a contradictory record).
43. The obvious inference to be drawn from Dr Haris's false denial, looked at by itself, is that he knew there was no innocent explanation for what he had done. The handwritten records in respect of Patient B are at least consistent with a bungled attempt to cover his tracks – why would notes of the examination of a patient presenting with upper back pain record that the doctor had not carried out examinations of her that were not clinically indicated? Of course, the MPT may well have decided to give the doctor the benefit of the doubt on the question of the records had they ever considered it– the point is that they did not consider it.
44. Thus Mr Leonard's point about the Tribunal's role as finders of primary fact and the advantages they had of seeing and hearing the witnesses does not support his submission that the Judge fell into error when she characterised their decision on the absence of sexual motivation as irrational. The Tribunal's approach was fundamentally flawed; the evidence which they accepted made no difference to the inferences reasonably to be drawn from the behaviour of the doctor and the fact he lied about it. The Judge was as well placed as they were to draw appropriate inferences from the relevant fact findings, and she did not fall into error when she did so.

Further submissions made in support of the MPT's findings

45. Mr Leonard maintained before us the submission he had made before Foster J, that the language of the allegations made by the GMC “left open possible findings of fact consistent with encounters taking place in the context of clinical activity which was clinically *motivated* if not clinically indicated.” In his written submissions he also stated that it was “difficult to understand why allegations of lack of gloves, consent and records would be made if it was not possible to view these allegations as taking place in the absence of sexual motivation.”
46. In my judgment, Foster J's description of this differentiation between clinical motivation and clinical indication based on the wording of the pleadings as “sophistry” was fully justified. What matters is what the Tribunal were satisfied actually happened. How it was described in the formal statement setting out the allegations made by the GMC against the doctor some years after the event makes no difference to the nature of the act or acts complained of. The nature of conduct and

the motivation for it are not matters which depend on how a lawyer chooses to describe it. The GMC did not need to *plead* that an inference was obvious, or that if the patients' version of events was believed this pointed to only one conclusion as to the likely motive for the conduct complained of, if it was and it did. Those are matters of submission.

47. In fairness to Mr Leonard, in his oral submissions he readily conceded these points. He explained that the point he was seeking to make was that the way in which the allegations were drafted did not *of itself* make the MPT's conclusion illogical, because it left open the possibility that they might find the factual allegations, or some of them, proved and yet still conclude that sexual motivation was not proved.
48. Theoretically that is correct, but some of the factual allegations (such as Dr Haris's touching of Patient A's side with his pelvis when he leaned across her) did leave open the possibility of accidental contact, whereas others did not. Moreover, there was nothing wrong in principle with first setting out each separate act complained of, so that the Tribunal can decide which, if any, is or are proved, and *then* requiring the Tribunal to give separate consideration to whether the acts that had been proved were sexually motivated, if and insofar as it was felt necessary to ask the Tribunal to consider that question.
49. What Dr Haris was alleged and found to have done in this case was far more intrusive and serious than what Dr Basson and Dr Jagjivan did. As Foster J recognized, what was essentially being alleged in this case was a series of sexual assaults, about which the doctor had lied, and therefore, strictly speaking, proof of sexual motivation was not essential to establish just how serious the conduct was. That was the point she was making when she suggested at [60] that the error into which the MPT fell could have been avoided by using a different formulation of the allegations against the doctor. She may well be right about that, but that does not mean that the formulation that *was* used gives rise to any basis for a Tribunal rationally concluding that the GMC had failed to prove, on the balance of probabilities, that the conduct in question was sexually motivated.
50. In any event, the GMC's case on the irrationality of the MPT's conclusion, and Foster J's finding that it was irrational, were not based on the way in which the allegations were pleaded. They were based upon the facts which the Tribunal found and the absence of any plausible innocent reason for Dr Haris doing what he did.
51. Mr Leonard's submission on the pleadings also overlooks the nature of the defence and the fact that Dr Haris was not telling the truth – both matters which Mr Leonard readily acknowledged left his client, and defence counsel before the MPT, in some forensic difficulty. There is no room whatsoever for a finding of clinical motivation for overtly sexual touching in a case in which the defence was that the patients had made up their stories and there was no touching at all. There was also no evidence on which the MPT could have found a clinical motivation (a finding which, in any event, the MPT did *not* make). In those circumstances there was no rational explanation for overtly sexual behaviour which was or could be given, other than that it was done for sexual gratification.
52. As for Mr Leonard's point that the allegations of failure to wear gloves, the failure to complete accurate records and the failure to obtain proper consent reflected the

possibility of an analysis related to clinical activity, Foster J said that this placed too much emphasis on what were merely allegations inserted to cover the (obviously culpable) failures to wear gloves or obtain consent or make accurate records. I agree, but I would also point out that if one is looking at matters on the basis of the balance of probabilities, those three factors overwhelmingly support the *absence* of clinical activity, because if, hypothetically, a doctor honestly but misguidedly thought a vaginal examination was called for, one would expect him to have obtained consent for it, worn gloves, and kept a proper record, or done at least one of those things.

53. Mr Leonard also took issue with Foster J's observations at [51] that the MPT became muddled as to what they had to ask themselves and concerned themselves unnecessarily with the burden of proof and/or evidential burdens. He took us to various passages in the transcripts to show that whilst there had been some discussion and debate about the shifting of the evidential burden if the GMC raised a *prima facie* case that the acts were sexually motivated, ultimately it was common ground between counsel who appeared before the MPT that the burden of proof of sexual motivation remained with the GMC, and the standard was the balance of probabilities, and that is how the legal adviser to the Tribunal put the matter without demur when the hearing was reconvened after a debate in private session about these matters.
54. It seems to me that the point that Foster J was making in her judgment was a fair reflection of that debate, which did indicate some degree of confusion. This was not a case which turned on who bore the burden of proof. The only question was whether it was more likely than not that the doctor's actions were sexually motivated. The Judge's observation was directed at what may have caused the MPT to approach the matter in the way they did at [112] and stop short in their analysis after accepting the evidence of the doctor's sister and friend and of Dr Vandenabeele, instead of considering whether that evidence provided a more likely explanation for what Dr Haris did than the obvious one. At the end of the day, however, it does not matter *why* the Tribunal went wrong, or whether the Judge's observation was justified, if she was right (as she was) to find that they reached a conclusion that was not reasonably open to them.
55. There was no question of the Judge's approach reversing the burden or standard of proof. The burden remained on the GMC throughout, but there was more than enough evidence to raise (at its lowest) a strong *prima facie* case of sexual motivation which would discharge that burden in the absence of an innocent explanation for what happened. There was no innocent explanation. The evidence that the touching was sexually motivated was overwhelming. That is not a matter on which the MPT was any better placed to form a view than the Judge. She was not obliged to defer to their findings on that issue when they had been reached after taking a fundamentally flawed approach to the evidence.
56. The other points made by Mr Leonard as to the size of the rooms in which the incidents took place, the lack of direct evidence of sexual motivation and the fact that Dr Haris knew of Patient A's complaint against him prior to his examination of Patient B may well have been relevant to the question whether the patients' versions of events were to be accepted, but they are not relevant to the question of what inferences are to be drawn from that fact that they *were* accepted. The fact that these events took place in a clinical setting does not point towards a clinical motivation. The setting just provided the opportunity for the inappropriate touching. There is

rarely any direct evidence of sexual motivation (though in some cases adverse inferences might be drawn from what was said by the doctor) and in a case like this, the facts speak for themselves.

Conclusion

57. In summary, Dr Haris's apparent lack of interest in a sexual relationship, and the consistency of his claimed asexuality with his recent diagnosis of Asperger's syndrome, do not begin to explain why he groped a patient's buttocks and breasts and performed physical examinations of her vagina and (on a different occasion) that of another patient, in each case without any clinical justification, without warning or obtaining prior consent, without giving or recording any reason for it at the time, and without using gloves. In the absence of a plausible innocent explanation for what he did, the facts spoke for themselves. A sexual motive was plainly more likely than not; I would go so far as to say that that inference was overwhelming.
58. Foster J was unquestionably right to find that the only rational conclusion available was that the allegation that the conduct was sexually motivated had been proved. In those circumstances she was justified in substituting a finding to that effect.
59. I would dismiss this appeal.

Lord Justice Phillips:

60. I agree.

Lord Justice Newey:

61. I also agree.