Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 27/07/2020 - 30/07/2020

Medical Practitioner's name:	Dr Dimitra KLEFTOGIANNI
GMC reference number:	7406965
Primary medical qualification:	Laurea 2000 Universita degli Studi di Roma "La Sapienza"

Type of case
New - Misconduct

Outcome on impairment
Impaired

Summary of outcome
Suspension, 2 months.

Tribunal:

Legally Qualified Chair	Mr Paul Moulder
Lay Tribunal Member:	Ms Wanda Rossiter
Medical Tribunal Member:	Dr Anita Clay

Tribunal Clerk:	Ms Jeanette Close

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Neil Sheldon, Counsel, instructed by Medical Defence Union
GMC Representative:	Mr Bob Sastry, Counsel

Attendance of Press / Public

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

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 and Impairment - 29/07/2020

Background

1. Dr Kleftogianni qualified in 2000 from Universita degli Studi di Roma "La Sapienza". Prior to the events which are the subject of the hearing Dr Kleftogianni worked as a General Practitioner and Staff Grade Doctor in Greece before commencing speciality training in General Adult Psychiatry there in February 2007. After completing her training, Dr Kleftogianni attained the title of Specialist in Psychiatry.

2. Dr Kleftogianni continued to work in various psychiatric roles within Greece before moving to the United Kingdom (UK) in September 2013, when she attained the position of Staff Grade Psychiatrist at the Priory Hospital, Middleton St. George, Darlington. Between November 2014 and July 2017 Dr Kleftogianni worked as Lead Consultant Psychiatrist at Cygnet Hospital, Taunton and since August 2017, and has continued to work at various NHS Trusts within the UK, as a Consultant Psychiatrist.

3. At the time of the events Dr Kleftogianni was practising as a locum Consultant Psychiatrist at Avon & Wiltshire Mental Health Partnership NHS Trust (the Trust) via Pulse Recruitment, working at Sandalwood Court, (SC) Swindon and Early Intervention in Psychosis Service, Chatsworth House, Swindon.

4. The allegation that has led to Dr Kleftogianni's hearing can be summarised as follows. During the course of her employment by the Trust, Dr Kleftogianni consulted with Patient A on 24 April and 22 May 2018. Following Patient A's discharge from the Trust on 22 May 2018, Dr Kleftogianni entered into an inappropriate emotional relationship with Patient A between 23 May 2018 and early July 2018. It is also alleged that Dr Kleftogianni communicated with Patient A by phone, attended Patient A's house and engaged in an inappropriate relationship with Patient A. It is further alleged that Dr Kleftogianni entered the relationship despite knowing Patient A was vulnerable due to a mental health condition.

5. Initial concerns were raised by Mr I, a mental health nurse at SC, following Patient A's referral to the Swindon Primary Care Liaison Service (PCLS) and a meeting with Patient A on 28 December 2018. During the meeting Patient A disclosed an alleged

intimate relationship with Dr Kleftogianni, which Mr I referred on to the relevant Safeguarding Team. A Trust investigation followed, during which Dr Kleftogianni was interviewed and made some admissions. Dr Kleftogianni was suspended pending further investigation. Thereafter a formal Trust investigation was carried out. Dr Kleftogianni was interviewed again on 24 January 2019 and at that meeting admitted to having had a personal relationship with Patient A. She stated that the relationship was intimate but had not involved sexual intercourse. The final report to the Trust concluded that the evidence showed that an improper personal relationship of an intimate nature had occurred.

6. Subsequently, on 25 January 2019, the GMC received a referral regarding Dr Kleftogianni's relationship with Patient A from Ms J, Safeguarding Enquiry Manager at Swindon Borough Council.

The Allegation and the Doctor's Response

7. The Allegation made against Dr Kleftogianni is as follows:

1. You consulted with Patient A on:

    a. 24 April 2018; **Admitted and found proved**

    b. 22 May 2018. **Admitted and found proved**

2. Patient A was discharged from the care of the Patient Care Liaison Service on 22 May 2018. **Admitted and found proved**

3. Between 23 May 2018 and July 2018, you:

    a. communicated with Patient A on the telephone; **Admitted and found proved**

    b. attended at Patient A's home address on approximately five occasions; **Admitted and found proved**

    c. engaged in a physical relationship with Patient A, during which you engaged in the following intimate acts:

        i. hugging; **Admitted and found proved**

        ii. kissing; **Admitted and found proved**

        iii. stroking; **Admitted and found proved**

        iv. caressing; **Admitted and found proved**

d. bought Patient A food and other household items for his house; **Admitted and found proved**

e. engaged in an emotional relationship with Patient A. **Admitted and found proved**

4. At all material times Patient A was:

a. a former patient; **Admitted and found proved**

b. vulnerable by reason of his mental health. **Admitted and found proved**

5. By reason of paragraph 1, you were aware of Patient A's mental health history. **Admitted and found proved**

6. Your actions as described at paragraph 3 were inappropriate by reason of paragraphs 4 and 5. **Admitted and found proved**

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

The Admitted Facts

8. At the outset of these proceedings Dr Kleftogianni, through her counsel Mr Neil Sheldon, admitted the entirety of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Determination on Impairment

9. In light of Dr Kleftogianni's response to the Allegation against her, there were no facts to be determined. The Tribunal next had to decide in accordance with Rule 17(2)(l) of the Rules, whether or not Dr Kleftogianni's fitness to practise is impaired by reason of her misconduct.

The Evidence

10. The Tribunal has taken into account all the evidence received during the hearing, both oral and documentary, as summarised below.

Witness Evidence

11. The GMC provided to the Tribunal written Witness Statements of its witnesses, each supported by a Statement of Truth. In accordance with the Rules, the Tribunal accepted these in evidence. Since Mr Sheldon did not require to cross examine these witnesses and the Tribunal had no additional questions, the written statements were accepted as the GMC's factual evidence.

12. Dr Kleftogianni gave oral evidence on day one of the proceedings. In addition, the Tribunal received oral evidence from the following witnesses on Dr Kleftogianni's behalf:

- Dr B, Consultant Psychiatrist, via Skype for Business, together with his testimonial, dated 28 April 2020.

Documentary Evidence

13. The Tribunal considered and analysed all documentary evidence adduced by the parties. The evidence included, but was not limited to:

- Witness Statement of Mr I, Mental Health Nurse, dated 21 June 2019;
- Completed safeguarding referral form from Mr I, Mental Health Nurse, dated 31 January 2018, together with his witness statement, dated 21 June 2019;
- Referral email to the GMC from Ms J, Safeguarding Enquiry Manager at Swindon Borough Council, dated 25 January 2019;
- The Trust's Investigation Report, dated 7 February 2019;
- Witness statement of Dr Kleftogianni, dated 21 April 2020, together with a supplemental statement, dated 1 July 2020;
- Witness statement of Dr C, Consultant Psychiatrist and Medical Lead, dated 30 May 2019;
- Witness statement of Dr D, Consultant Psychiatrist, dated 7 June 2019;
- Three reports from Dr B, Consultant Psychiatrist, and Dr Kleftogianni's Supervisor, dated 24 October 2019, 17 January 2020 and 23 April 2020;
- GMC Guidance 'Maintaining a professional boundary between you and your patient', dated 25 March 2013;
- Certificate of Attendance for 'Maintaining Professional Boundaries' training course, dated 13-15 May 2019
- Certificate for completion of an online course 'Professional Boundaries in Health and Social Care level 2', dated 11 April 2020;
- Patient and 360 Feedback, various dates.

14. The Tribunal also received evidence on behalf of Dr Kleftogianni in the form of testimonials from the following witnesses who were not called to give oral evidence:

- Dr E, Consultant Psychiatrist and Medical Psychotherapist, dated 6 April 2020;
- Dr F, Consultant Psychiatrist, dated 14 April 2020;
- Dr G, Medical Director, dated 24 April 2020;
- Dr H, Locum Consultant Psychiatrist, via telephone link, together with his testimonial, dated 29 April 2020.

Submissions

On behalf of the GMC

15. On behalf of the GMC, Mr Bob Sastry submitted that the case before the Tribunal related to boundary transgression, which amounted to serious misconduct and therefore a finding of impairment was required as defined by the Medical Act 1983.

16. He referred the Tribunal to the case law of *Roylance vs GMC (2) [2000]1AC 311* as to the meaning of misconduct, which is conduct which falls short of what is proper in the circumstances.

17. Mr Sastry directed the Tribunal's attention to the GMC's guidance *'Maintaining a professional boundary between you and your patient'* (March 2013) (the supplementary guidance). Mr Sastry referred in particular to paragraphs 3, 8, 9 and 11 to 13 of the guidance and submitted that all were relevant in this case.

18. He stated that Dr Kleftogianni should have known of the guidance and been familiar with it, however she had involved herself in an improper personal and physical relationship with Patient A, after he had been discharged from her clinical care, which constituted a serious breach of the guidance.

19. He stated that at the material time Patient A was an emotionally unstable patient having been diagnosed with 'borderline personality disorder'. Mr Sastry submitted that patients with this diagnosis often suffered from fear of abandonment and that was what Dr Kleftogianni had done.

20. Mr Sastry stated that the capacity for mental harm to Patient A as a result of Dr Kleftogianni engaging in a relationship with him was huge. He stated that harm to Patient A was evidenced by him having to return to the Trust seven months later for further mental health treatment after his relationship with Dr Kleftogianni had ended. Mr Sastry submitted that Dr Kleftogianni's actions were inconsistent with the overarching objective to protect patients. He referred the Tribunal to paragraph 1 of *'Good Medical Practice'* (2013) (GMP):

> *'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.'

21. Mr Sastry submitted that Dr Kleftogianni was a very experienced psychiatrist with a depth of experience and that it was therefore surprising that she did not know of and had not read the available supplementary GMC guidance. He stated that if she had she would have been warned about engaging in an emotional and physical relationship with a vulnerable former patient.

22. Mr Sastry acknowledged the efforts Dr Kleftogianni had made to address and remediate her conduct. He stated that this was evidenced by the fortnightly meetings she had with Dr B, her supervisor and the progress she had made since the relevant time. He submitted that although Dr B had spoken well of Dr Kleftogianni, he could not rule out the risk of repetition.

23. Mr Sastry stated that there was a real possibility that Dr Kleftogianni would have to move to another post at some point in the future and if that were to happen, the absence of support, which had occurred at the material time could result in repeated misconduct. Mr Sastry stated that if Dr Kleftogianni was presented with a series of identical circumstances there was a real risk of repetition of her conduct.

24. Mr Sastry submitted that only a finding of impairment can properly deal with Dr Kleftogianni's misconduct and satisfy the overarching objection to protect members of the public and maintain confidence in both the practitioner and the profession. He referred the Tribunal to the case law of *Yeong v GMC [2009] EWHC 1923 (Admin).*

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

25. Mr Sheldon said that he did not suggest that Dr Kleftogianni's conduct did not amount to misconduct. He submitted that Dr Kleftogianni had never sought to minimise or explain away her conduct and that from the very start she had profoundly and deeply regretted her conduct and had accepted that Patient A was a vulnerable patient. Mr Sheldon stated that Dr Kleftogianni had acknowledged the power imbalance between herself as a practitioner and Patient A and that she had been candid and frank in her interview with Dr C.

26. Mr Sheldon reminded the Tribunal that at the material time Patient A was a former patient of Dr Kleftogianni and that GMP only refers to current patients in the context of inappropriate relationships. He stated that the guidance regarding former patients was more ambiguous and that there was a significant and important difference between relationships with current and former patients.

27. Mr Sheldon stated that the relationship between Dr Kleftogianni and Patient A was an emotional relationship, with limited physical contact and that it was not sexual. He stated that there was an important and significant difference between an emotional and a sexual relationship.

28. With regards to Patient A suffering harm as a result of the relationship with Dr Kleftogianni ending, Mr Sheldon submitted that there was no conclusive evidence to suggest that the ending of the relationship caused a deterioration in Patient A's mental health thereby causing him mental harm.

29. Mr Sheldon stated that Dr Kleftogianni accepted that Patient A was an emotional and vulnerable patient due to his borderline personality disorder and that as a result he would suffer abandonment issues and more than likely be vulnerable to future emotional trauma. He stated that Patient A had begun to be angry with Dr Kleftogianni towards the end of the relationship and had expressed this to her. Mr Sheldon submitted that there was no evidence presented by the GMC of harm caused to Patient A. He stated that it was some six months after the relationship had ended and Dr Kleftogianni had moved to a different role that Patient A was referred back to the Trust. He stated that there was no evidence as to what prompted the referral and no evidence from Patient A himself, nor were there any allegations that Dr Kleftogianni had caused a deterioration in Patient A's health.

30. Mr Sheldon submitted that when Dr Kleftogianni had first been interviewed by Dr C she had shown insight into her wrongdoing and why it was wrong. Mr Sheldon stated that at the material time Dr Kleftogianni had not been aware of the standards regarding professional boundaries but that now she was fully aware. He stated that Dr Kleftogianni had learnt an important lesson and had learnt it the hard way and that she had demonstrated clear, reflective and thorough insight as affirmed by her colleagues.

31. Mr Sheldon submitted that Dr Kleftogianni could have done no more than she had to remediate the failings in her practice. He stated that Dr Kleftogianni had done an enormous amount of work reflecting on the standards in relation to relationships with patients. She had completed a professional boundaries course as well as an online boundaries course, she had completed research and had read many articles regarding this subject as well as reflecting personally. Mr Sheldon stated that Dr Kleftogianni was now able to fully understand what had gone wrong and what had led her to engaging in a relationship with Patient A. Mr Sheldon reminded the Tribunal that the GMC had not challenged the fact that Dr Kleftogianni had done all that she could possibly have done to remediate her conduct.

32. Mr Sheldon submitted that the Tribunal could have the utmost confidence that nothing of this sort would ever happen again, and that Dr Kleftogianni had carefully reflected and fully understood what had gone wrong and had put it right. He stated that Dr Kleftogianni had adopted sensible and effective measures to

ensure that there would not be a repetition of this conduct again. He submitted that the impact of these events had had a profound effect on Dr Kleftogianni, emotionally, financially and professionally and the powerful impact would ensure she would not act in the same way if she found herself in a similar situation.

33. Mr Sheldon submitted that this was a single isolated lapse of judgment in a 20 year career and that nothing remotely similar had happened prior to these events or since. He reminded the Tribunal that everyone makes mistakes, even doctors and that a fair-minded member of the public would accept that doctors made mistakes, but would expect a doctor to never repeat that mistake.

34. Mr Sheldon submitted that a finding of no impairment would not mean that the doctor had 'got away with it', as Dr Kleftogianni had suffered the consequences of her actions. She had suffered the consequences to her career, as well as the financial consequences. He reminded the Tribunal that Dr Kleftogianni had been working under conditions imposed by an IOT for over a year and that she has had this case hanging over her head for almost 2 years.

35. Mr Sheldon submitted that this case did not require a finding of impairment as Dr Kleftogianni had developed full insight and had undertaken full remediation and that there was no risk of repetition. He submitted that the case could be concluded with a warning, in the event that impaired fitness to practise was not found.

The Relevant Legal Principles

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

37. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts found proved amounted to misconduct, including whether the misconduct was serious; and second whether Dr Kleftogianni's fitness to practise is currently impaired by reason of misconduct.

38. The Tribunal must determine whether or not Dr Kleftogianni's fitness to practise is impaired today, taking into account her conduct at the time of the events and any relevant factors since then, such as whether the matters are remediable, have been remedied and any likelihood of repetition.

39. Throughout its deliberations, the Tribunal was mindful of its responsibility to uphold the overarching objective as set out in the Medical Act 1983 (as amended). That objective is:

> *'a. to protect, promote and maintain the health, safety and wellbeing of the public;*

b. to maintain public confidence in the profession;
c. to promote and maintain proper professional standards and conduct for members of the profession.'

40. The Tribunal also had regard to paragraphs 3, 8, 9 and 11 to 13 of the supplementary guidance:

'3 Trust is the foundation on the doctor-patient partnership. Patients should be able to trust that their doctor will behave professionally towards them during consultations and not see them as a potential sexual partner.
…
8 Personal relationships with former patients may also be inappropriate depending on factors such as:

a the length of time since the professional relationship ended (see paragraphs 9–10)

b the nature of the previous professional relationship

c whether the patient was particularly vulnerable at the time of the professional relationship, and whether they are still vulnerable (see paragraphs 11–13)

d whether you will be caring for other members of the patient's family.

You must consider these issues carefully before pursuing a personal relationship with a former patient.

9 It is not possible to specify a length of time after which it would be acceptable to begin a relationship with a former patient. However, the more recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate.
…

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

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

13 Whatever your specialty, you must not pursue a personal relationship with a former patient who is still vulnerable. If the former patient was vulnerable

at the time that you treated them, but is no longer vulnerable, you should be satisfied that:

- *the patient's decisions and actions are not influenced by the previous relationship between you*
- *you are not (and could not be seen to be) abusing your professional position.'*

The Tribunal's Determination on Impairment

41. The Tribunal found Dr Kleftogianni to be a credible and honest witness who was candid in her evidence. She accepted her failings and wrongdoing and answered questions put to her honestly even when the response was detrimental to her case. For example, when asked whether she would accept a substantive post at the Trust for which she now worked, Dr Kleftogianni stated that whilst it would make things easier for her, due to the XXX mechanisms which had been put in place for her, she did not feel she was ready, at the present time, to accept a substantive post. At times, Dr Kleftogianni became emotional when asked or speaking about her own personal circumstances and the Tribunal accepted this to be genuine. The Tribunal accepted Dr Kleftogianni's evidence in relation to the steps she has taken to remediate her conduct. The Tribunal was satisfied that Dr Kleftogianni has fully cooperated throughout the investigation by the Trust and these proceedings and has at all times sought to assist the process.

42. The Tribunal found Dr B, an experienced consultant psychiatrist of about ten years and Dr Kleftogianni's clinical supervisor for some 15 months, to be an open and honest witness. His evidence was considered and measured and he gave clear answers to questions put to him, including his reasons as to why he considered that Dr Kleftogianni did not present any risk of repeating her conduct. The Tribunal accepted his evidence that if he thought there was such a risk, he would not want Dr Kleftogianni to continue to work at the Trust. The Tribunal noted the positive testimonials provided by Dr Kleftogianni's clinical colleagues attesting to her good character and good work.

<u>Misconduct</u>

43. The Tribunal accepted that at the material time Dr Kleftogianni believed that she was supporting Patient A and that this was an emotional relationship, and it bore in mind that it was not a sexual one. It had regard to Dr Kleftogianni's personal circumstances at the time XXX, that she was working in a new post, in a new area, and that at that time she had made no friends. She was missing her family in Greece and she was lonely.

44. It reminded itself that in her interview with Dr C Dr Kleftogianni had stated that she had confused her relationship with Patient A as romantic love. In oral evidence Dr Kleftogianni stated that she had been somewhat confused when explaining this. It further noted that the relationship had progressed to kissing and stroking and types of intimacy that Dr Kleftogianni had described as offering support and comfort to someone who was upset and crying and had likened it to comforting a family member.

45. The Tribunal noted that in her witness statement Dr Kleftogianni had stated that she was lonely, she was missing her family in Greece and was unable to comfort them at a time when they had suffered the loss of family members. In her oral evidence Dr Kleftogianni stated that she had been missing physical contact at the time. The Tribunal concluded that, in addition to supporting Patient A, Dr Kleftogianni had been supporting her own XXX by pursuing a relationship with Patient A and that at the material time Dr Kleftogianni was not fully considering what was best for Patient A.

46. The Tribunal accepted that there was no direct evidence before it of consequential harm to Patient A which had caused his being referred back to the Trust some seven months after his relationship with Dr Kleftogianni had ended. The Tribunal accepted that Patient A had a borderline personality disorder. It noted from the evidence that patients with this diagnosis suffer from abandonment issues. There was also evidence of Patient A becoming angry with Dr Kleftogianni towards the end of their relationship, around the time that she had tried to withdraw from the relationship. The Tribunal concluded that on the balance of probabilities Dr Kleftogianni's ending of the relationship caused some distress to Patient A and that Dr Kleftogianni had exposed him to the risk of psychiatric harm because of his vulnerable mental health. Dr Kleftogianni had admitted that she knew of Patient A's vulnerable condition. The Tribunal concluded that some harm had resulted to Patient A as a result of Dr Kleftogianni's actions. Further, the Tribunal was satisfied that, in light of her training and knowledge, Dr Kleftogianni ought to have been aware that such distress might result. When asked about how Dr Kleftogianni had, at the time, anticipated the progression and outcome of the relationship, she was unable to give an answer.

47. The Tribunal accepted that this episode of misconduct amounted to a single course of conduct in an otherwise unblemished career of considerable duration. However, it was also relevant that this course of conduct was carried out very shortly following the patient's discharge from the service, in the case of a vulnerable psychiatric patient and involved a series of some 4 or 5 visits. It was also relevant that, it was the doctor's evidence that, during the first consultation, Patient A had complimented Dr Kleftogianni and asked if he could 'ask her out'. Dr Kleftogianni had rightly refused, realising this had been inappropriate. The Tribunal concluded that Dr Kleftogianni ought to have realised that Patient A was likely to misunderstand the emotional support she was providing him.

48. The Tribunal noted that both parties agreed that Dr Kleftogianni's actions in the facts found proved amounted to professional misconduct. In considering the whole of the facts and evidence, the Tribunal concluded that Dr Kleftogianni had engaged, partly for her own XXX, in an emotional relationship with a vulnerable patient, which carried on for about a month and resulted in some distress to him. The Tribunal concluded that the facts admitted and found proved amounted to professional misconduct.

Impairment

49. The Tribunal next went on to consider whether, as a result of that misconduct, Dr Kleftogianni's fitness to practise is currently impaired.

50. The Tribunal acknowledged the amount of detailed and sustained reflection and discussion that Dr Kleftogianni had undertaken, commencing with CPD very soon after the events. It concluded that although she had had little insight at the time and had not self-referred the event, since the events of 2018 Dr Kleftogianni has fully developed her insight. Dr Kleftogianni has shown remorse and apologised for her conduct.

51. The Tribunal noted that in her interview with Dr C, Dr Kleftogianni had made a full and open disclosure regarding her personal situation and family issues and that she had not sought to excuse herself, but instead had tried to explain. The Tribunal noted that the courses Dr Kleftogianni had completed were appropriate, it also had regard to the extended discussions she had with her supervisor Dr B, and with her mentor Dr H. It also acknowledged that Dr Kleftogianni had thoroughly examined her motivation, had given a full and frank open assessment of her conduct and it considered that Dr Kleftogianni had developed full insight at this stage.
Dr Kleftogianni's gaining of insight was supported in some of the testimonials provided.

52. The Tribunal next considered whether Dr Kleftogianni had fully remediated her misconduct. The Tribunal noted that Dr Kleftogianni's relationship with Patient A was not sexual, but had concluded that at the material time due to her own personal issues, Dr Kleftogianni had sought to satisfy her own needs above her professional duties.

53. In view of Dr Kleftogianni's long and unblemished career, in which this was a single episode, when taken with the particular prevailing personal difficulties that she had been experiencing, the Tribunal concluded that this had been an exceptional case of falling into error and not evidence of deeper-seated issues. Accordingly, in the Tribunal's view, this misconduct was remediable.

54. The Tribunal reminded itself of the courses and CPD that Dr Kleftogianni had undertaken, the material she had read and the XXX. The Tribunal considered that having a mentor and supervisor had helped Dr Kleftogianni to remediate further. It accepted that she had been able to form a series of appropriate strategies in order to deal with any possible future boundary issues, indicating another level of remediation. The Tribunal determined that Dr Kleftogianni had done all that one could reasonably be expected to do to remedy her misconduct.

55. The Tribunal noted the GMC submission that Dr B had stated that one can never rule out the risk of repetition. However, it also noted that Dr B's evidence was that repetition was unlikely. The Tribunal considered that, in light of Dr Kleftogianni's full insight, developed understanding and reliable strategies, such conduct was highly unlikely to be repeated, even if Dr Kleftogianni were to be placed in similar circumstances in the future. The Tribunal considered that Dr Kleftogianni had learnt from this experience and had suffered the consequences of her actions. It determined that the extent of the remediation Dr Kleftogianni had undertaken, the strategies now in place and the consequences of future misconduct, were all likely to be effective deterrents.

56. The Tribunal next considered the public interest and whether a well-informed member of the public would expect a finding of impairment given the circumstances of this case. The Tribunal reminded itself that in cases involving breaches of fundamental tenets, efforts at remediation may be of less effect.

57. The Tribunal acknowledged that at the material time Dr Kleftogianni had a number of personal issues in her life and that this was a particularly emotional time for her. However, it considered that although the relationship with Patient A was not a sexual one, Dr Kleftogianni had been using the relationship to support her own emotional and physical needs at the time.

58. The Tribunal considered that by entering into a relationship with Patient A, Dr Kleftogianni had breached a fundamental tenet of the profession, of not causing harm to a patient. The Tribunal acknowledged the submission of Mr Sheldon that there was no evidence of any harm coming to Patient A, but it considered that there was evidence in his reactions to Dr Kleftogianni at the end of the relationship that Patient A had suffered some harm by Dr Kleftogianni's actions. It reminded itself that Dr Kleftogianni could not explain her motive when asked and that looking back on it now said she recognised that it was a poor decision on her part and a failure of judgement.

59. The Tribunal reminded itself of the proximity of the discharge of Patient A and the start of the relationship between Patient A and Dr Kleftogianni. Whilst it was correct that, by the time the relationship commenced, Patient A was a former, not a current patient, due to the short time elapsed, to commence on a relationship had still been clearly inappropriate. The Tribunal reminded itself that the supplemental

guidance sets out clear factors for consideration such as the length of time since the professional relationship ended, the vulnerability of the patient and the fact that Dr Kleftogianni was a psychiatrist. All these factors should have warned against commencing a relationship. Whilst the Tribunal accepted that Dr Kleftogianni was not aware of the supplemental guidance in its view she should have been aware of it or her professional skills and knowledge should have warned her against a relationship. The Tribunal considered that Dr Kleftogianni had had more than one opportunity to reflect on her actions but she had continued to visit Patient A at his home on 4 or 5 occasions.

60. The Tribunal reminded itself that at Dr Kleftogianni's first consultation with Patient A, he had complimented her and had asked if he could 'ask her out' but Dr Kleftogianni had made it clear to Patient A that it was not appropriate for her to do so. The Tribunal considered that this had been the correct response and should have been a warning to her, but soon afterwards Dr Kleftogianni had entered into a relationship with Patient A.

61. The Tribunal was mindful of the overarching statutory objective of the GMC in the Medical Act 1983 (as amended), which includes the need to uphold proper professional standards and maintain public confidence in the medical profession. The Tribunal concluded that, it would undermine public confidence and be prejudicial to standards expected of a practitioner, for the Tribunal not to make a finding of impaired fitness to practise in the case of a doctor with the level of experience and qualification of this doctor who has failed to appreciate the serious inappropriateness of entering into a relationship with a former patient in all the surrounding circumstances and in doing so, put her own emotional needs ahead of her professional obligations to the patient.

62. The Tribunal considers that public confidence in the profession and proper professional standards would be undermined if a finding of impairment were not made. Accordingly, the Tribunal find that Dr Kleftogianni's fitness to practise is currently impaired by reason of her misconduct.

Determination on Sanction - 30/07/2020

63. Having determined that Dr Kleftogianni'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

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

65. The Tribunal received the following further evidence on behalf of Dr Kleftogianni:

- The determination of another doctor's case by another Tribunal, dated October 2016;
- Article from the British Medical Journal, 'GP who had one night stand with patient is suspended for a month', dated 12 October 2016.

Submissions

66. On behalf of the GMC, Mr Sastry submitted that the appropriate sanction in this case was one of suspension. He referred the Tribunal to the overarching objective and the relevant paragraphs of the Sanctions Guidance (November 2019) (SG).

67. He submitted that Dr Kleftogianni had breached a fundamental tenet of the profession and this was a serious breach of GMP, which was the benchmark that doctors were expected to meet. Referring to paragraph 12 of the SG, Mr Sastry stated that Dr Kleftogianni should be familiar with and follow all of the guidance available to her as a practitioner.

68. Mr Sastry submitted that Dr Kleftogianni had transgressed professional boundaries as a psychiatrist by engaging in an emotional and physical relationship with a vulnerable patient and within a close proximity to the end of that patient's treatment.

69. Mr Sastry reminded the Tribunal of its determination on facts and impairment, where it had concluded on the balance of probabilities that Dr Kleftogianni had caused some distress and some psychiatric harm to Patient A when she withdrew from the relationship.

70. Mr Sastry accepted that Dr Kleftogianni had at the outset acknowledged her faults and mistakes to Dr C at the Trust. He stated that it was clear that since then Dr Kleftogianni had made significant efforts to remediate and that she had shown high levels of insight as attested to by Dr Kleftogianni's supervisor, Dr B in his oral evidence. Mr Sastry submitted that although the Tribunal had taken account of Dr Kleftogianni's high level of insight and remediation in its determination on facts and impairment, that did not justify it taking no action against Dr Kleftogianni.

71. Mr Sastry urged the Tribunal to view the additional documents presented to it by Mr Sheldon with caution and to place no reliance on it. He stated that the record of determination referred to unknown factors which had been redacted, so that the determination offered no value to these proceedings and that the documents were not binding in any way. He said that the documents related to a determination from a different Tribunal who were considering different facts to those presented in this case and therefore no legal point of principal could be derived from them. Mr Sastry

submitted that nothing could be gained from considering the material in relation to that case.

72. Mr Sastry reminded the Tribunal that it should consider the least restrictive sanction first and move upwards before stopping at the one that the Tribunal determined was applicable. He invited the Tribunal to take into account the principles of proportionality, weighing the interest of the public against those of the doctor, even if it determined to impose a sanction that led to difficulties for the doctor.

73. Mr Sastry submitted that this case did not fall into the category of cases in which it was appropriate to take no action. He stated that there were no exceptional, rare, unusual or uncommon circumstances in this case and that it would be wrong for the Tribunal to conclude it by taking no action against Dr Kleftogianni's registration, given its findings on misconduct and impairment.

74. Mr Sastry submitted that the guidance made it clear that conditions were not appropriate in this case. He stated that the purpose of conditions as contained within paragraphs 79, 80, 81 and 84 of the SG were not engaged. He submitted that it is clear that Dr Kleftogianni is highly spoken of as a doctor, that no clinical concerns had been raised and Dr Kleftogianni had shown insight and remediation. Mr Sastry submitted that to impose a period of conditions on Dr Kleftogianni's registration would not assist in this case.

75. Mr Sastry invited the Tribunal to consider imposing a period of suspension on Dr Kleftogianni's registration and referred the Tribunal to paragraph 93 of the SG. He stated that Dr Kleftogianni had acknowledged her fault in this case and he reminded the Tribunal of its determination on facts and impairment and its view that this is a doctor who had done so much remediation that the likelihood of repetition was low. He stated that a period of suspension would be appropriate in this case as the Tribunal was satisfied that there had been no repetition of similar behaviour and that Dr Kleftogianni did not pose a significant risk of repeating this behaviour.

76. Mr Sastry submitted that given the findings of the Tribunal together with the strong efforts Dr Kleftogianni had made to develop her insight and to remediate her conduct, this was not a case that was suitable for erasure.

77. Mr Sastry submitted that a finding of impairment alone would not satisfy the need to send a strong message to the public and members of the profession that behaviour and conduct of this kind is inappropriate. Mr Sastry submitted that a period of suspension was the appropriate sanction in this case.

78. On behalf of Dr Kleftogianni, Mr Sheldon submitted that suspension would be wholly disproportionate in this case. He submitted that it was important to take an appropriate approach to sanction, starting at the lowest sanction, only move up if

necessary and take only such action as needed to protect the reputation of the profession.

79. Mr Sheldon reminded the Tribunal of the mitigating factors in this case and stated that unusually and exceptionally, all of the key mitigating factors as defined by the SG were present in this case and to a significant degree.

80. Mr Sheldon stated that the Tribunal had already accepted that Dr Kleftogianni had developed full insight and from the very beginning had acknowledged her fault when the allegations of her relationship with Patient A had been presented to her by the Trust. Mr Sheldon stated that since then Dr Kleftogianni had applied herself carefully to reflection, remediation and sophisticated understanding and that her insight was now full and complete. The evidence was that other than this lapse, Dr Kleftogianni had adhered to the principles of GMP.

81. Mr Sheldon reminded the Tribunal that this was an isolated lapse of judgement in an otherwise unblemished career of high quality and had occurred at a time when Dr Kleftogianni was grappling with a number of personal issues. He stated that it was important to remember that at the material time Patient A was a former not a current patient and that since then there has been no repetition of similar conduct.

82. Mr Sheldon submitted that, it was clear that the events arose because of a combination of difficult personal issues, including isolation, relationship breakdown and multiple bereavements. He reminded the Tribunal that it had accepted the honesty of Dr Kleftogianni in giving her account of these factors.

83. Mr Sheldon submitted that it was relevant that there had been a lapse of time of over 2 years since the events in question, and no suggestion of repetition of such misconduct. He reminded the Tribunal that it had found at the Impairment stage that Dr Kleftogianni had done all that could be reasonably expected of her towards her remediation and that her remediation was complete.

84. Mr Sheldon pointed the Tribunal to the references and testimonials provided and submitted that they were of the highest quality and from senior clinicians, exhibiting a strength and breadth. He submitted that Dr Kleftogianni had made appropriate expressions of regret and apology, which she stood by; there was no question of her sincerity, and that she had taken full responsibility for her actions and had completely engaged with the GMC.

85. Mr Sheldon submitted that the key mitigating factors as indicated in the SG were present to a very significant degree.

86. Mr Sheldon submitted that the Tribunal should have regard to the nature of the guidance in issue. This was not a case of a breach of GMP, but rather a breach of supplementary guidance in place which was in addition to GMP, namely

'Maintaining a professional boundary between you and your patient'. Mr Sheldon stated that the guidance breached in this case was not found in GMP but in the supplementary guidance and that it was important not to confuse a breach of GMP, the fundamental core and tenet of the profession, with a breach of the supplementary guidance. Mr Sheldon stated that at the material time Patient A was not Dr Kleftogianni's patient and that this case related to a former patient and that it had not been alleged that Dr Kleftogianni had used her professional position to pursue Patient A.

87. Mr Sheldon submitted that it was important for the Tribunal to bear in mind the need for consistency in decision-making, particularly if the rationale was sending out a clear message to the profession and declaring and upholding clear standards. He referred the Tribunal to the facts of the other determination, in which there had been a sexual relationship and a clear breach of GMP. He submitted that the Tribunal should have regard to the outcome and reasoning in that determination.

88. Mr Sheldon submitted that throughout many iterations, the SG had always stated that taking no action should be reserved to exceptional cases, but that the option was available because there would be such cases. Although relatively rare, in the right case, taking no action was the right thing to do, and this was precisely such a case.

89. Mr Sheldon submitted that Dr Kleftogianni's was a case of full insight and full remediation, to what can only be described as to an exceptional degree. He stated that other key features were relevant in this case also, namely the profound and acute public interest in Dr Kleftogianni being allowed to work and devote her energy to vulnerable patients, who need her desperately, the impact a break in the continuity of care would have and the disruption to the therapeutic relationship Dr Kleftogianni has with her patients if a suspension were to be imposed on her registration. He stated that the service would suffer if Dr Kleftogianni were unable to continue working.

90. Mr Sheldon stated that Dr Kleftogianni had already been working under conditions for over a year, including the onerous condition of supervision to which she has assiduously adhered. She had spent dozens of hours of reflective remediation, discussion and analysis not just with Dr B, her supervisor, but also with Dr H, her mentor.

91. Mr Sheldon submitted that these features go beyond insight, remediation, apology and remorse and together are sufficient to put them within the exceptional category of taking no action. He stated that if not this case, for all the reasons given, it would be very difficult to envisage any other case where it would be appropriate to take no action, particularly where guidance and legislation has expressly reserved its use by a Tribunal.

92. Mr Sheldon stated that if the Tribunal considered that taking no action was not appropriate, the next step to consider would be to impose conditions. He stated that conditions would be neither necessary not appropriate in this case as Dr Kleftogianni can do no more than she already has to demonstrate her remediation.

93. Mr Sheldon submitted that a period of suspension would be a wholly disproportionate step in this case. He warned the Tribunal to be careful to regard some paragraphs of the SG concerning suspension as setting out reasons for not going further along the sanctions ladder, to erasure, rather than being positive reasons for imposing a suspension. However, if the Tribunal were to conclude that a period of suspension was necessary then it should be for the very shortest period possible and be measured in weeks and not in months.

The Tribunal's Determination on Sanction

94. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal alone, exercising its independent judgement.

95. In reaching its decision, the Tribunal has taken account of the SG. It has borne in mind that although sanctions are not imposed to punish or discipline doctors, they may have a punitive effect.

96. The Tribunal has given consideration to its findings of misconduct and impaired fitness to practise as well as the submissions made by Mr Sastry on behalf of the GMC, and Mr Sheldon on behalf of Dr Kleftogianni.

97. Throughout its deliberations the Tribunal bore in mind that the purpose of sanctions is not to be punitive, but to uphold the Overarching Objective. In making its decision, the Tribunal also had regard to the principle of proportionality, and it considered Dr Kleftogianni's interests as well as those of the public. It also considered and balanced the mitigating and aggravating factors in this case.

<u>Aggravating and Mitigating factors</u>

98. The Tribunal identified the following aggravating factors:

- Dr Kleftogianni had abused her professional position;
- Dr Kleftogianni put her own needs above those of Patient A;
- Patient A was a vulnerable patient;
- Dr Kleftogianni had caused some harm to Patient A.

99. The Tribunal also identified the following mitigating factors:

- An isolated set of events in a long career;

- Dr Kleftogianni was suffering significant personal circumstances at the time of the events;
- Dr Kleftogianni has developed full insight into her past misconduct;
- Significant remediation undertaken by Dr Kleftogianni;
- Appropriate expressions of regret and apology by Dr Kleftogianni;
- Positive references and testimonials.

100. The Tribunal had regard to paragraphs 3, 53 and 65 of GMP:

'3 Good medical practice describes what is expected of all doctors registered with the General Medical Council (GMC). It is your responsibility to be familiar with Good medical practice and the explanatory guidance which supports it, and to follow the guidance they contain.

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

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

101. The Tribunal had regard to the submissions made by Mr Sheldon that Dr Kleftogianni had not breached a fundamental tenet of GMP, rather that she had breached supplementary guidance. The Tribunal noted the suggestion made by Mr Sheldon that there was a hierarchy of guidance and that GMP was the core guidance with other supplementary guidance being of less importance and that care should be taken not to confuse a breach of GMP with a breach of the supplementary guidance.

102. The Tribunal did not agree with Mr Sheldon's submission that Dr Kleftogianni had breached only the lesser guidance and not the GMP and therefore it was not as serious. The Tribunal considered that the SG makes it clear that the supplementary guidance should be viewed as an explanation of, and support to the core guidance of GMP. In the view of the Tribunal, the paragraphs of GMP as set out above were engaged, albeit that the supplementary guidance on boundaries made clear that there were a range of relevant factors to be considered in the case of a relationship with a former patient. In this case, the Tribunal had found that, applying those factors, this relationship with a former patient had been inappropriate, and, to her credit, Dr Kleftogianni now acknowledged this.

103. The Tribunal had regard to the determination of the 2016 Tribunal, which Mr Sheldon presented to the Tribunal as a comparable determination and his request for the Tribunal to show consistency with the outcome of that case. The Tribunal noted that that case related to a doctor who had engaged in a sexual relationship with a patient, with one episode of sexual intercourse, who had self-reported and who subsequently received a one month suspension.

104. The Tribunal considered that, whilst consistency in decision-making was a legitimate aim, it was incumbent on each Tribunal to reach its decision on application of the SG according to its own findings. It was clear that there had been some redactions from the determination provided of potentially relevant facts and it had not been submitted that there was any binding effect from other determinations, which was correct. The other determination provided was as to a single case from the determinations reached in the large number of cases heard by Tribunals and this Tribunal was not able to tell if it was representative.

105. The Tribunal concluded that the only way it could achieve a consistent outcome was by applying the SG consistently and rationally to any decision it made.

No action

106. The Tribunal first considered whether it should conclude this case by taking no action. It reminded itself of its findings that Dr Kleftogianni's had developed full insight and had fully remediated her conduct and that she had done all that she could be expected to do to demonstrate it.

107. However, the Tribunal considered that this level of insight and remediation was no more than that which was expected of a doctor who had erred and whose fitness to practise was impaired, but had then remediated her misconduct. The Tribunal determined that Dr Kleftogianni's level of insight, remediation, remorse and apology did not fall into a category which could properly be regarded as exceptional circumstances allowing it to determine that no action should be taken. The Tribunal determined that it would not be appropriate to end this case by taking no action.

Conditions

108. The Tribunal next considered whether to impose a period of conditions on Dr Kleftogianni's registration. It noted the submissions from both parties that conditions were neither appropriate nor necessary in this case.

109. The Tribunal took into account that Dr Kleftogianni has already fully remediated and that no more could be achieved by imposing a further period of conditions and that it was not appropriate or necessary in this case to make an order of conditions.

Suspension

110. The Tribunal next considered whether it should impose a period of suspension on Dr Kleftogianni's registration and had regard to paragraphs 91, 92, 93 and 97a, f and g of the SG:

> *91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> *93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions (see paragraphs 24–49).*
>
> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*
>
> > *a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.*
> > *…*
> >
> > *f No evidence of repetition of similar behaviour since incident.*
> >
> > *g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

111. The Tribunal determined that Dr Kleftogianni had breached a fundamental tenet of the profession and that she had abused her professional position by entering into an inappropriate emotional and physical relationship with Patient A and that this was a serious breach of GMP. The Tribunal noted paragraphs 142 – 145 of the SG, and noted this was an abuse of a professional relationship with a vulnerable patient, thereby justifying a more serious sanction.

112. The Tribunal considered that Dr Kleftogianni had acted in breach of the sections of GMP set out above. She had failed her responsibility to be familiar with the terms of the supplementary guidance, which itself was a requirement of GMP. She had engaged in an improper emotional and physical relationship with a former patient, which goes against the advice in the supplementary guidance and she had acted in breach of trust.

113. The Tribunal considered the effect on continuity of patient care and the effect on Dr Kleftogianni if it were to impose a period of suspension. It acknowledged that isolation and exclusion had been problems in the past for Dr Kleftogianni but that she now had strategies in place, including a work life balance to deal with those issues. It also acknowledged that the public would be deprived of the services of an experienced and competent doctor for a period. However, it had to balance those issues with the public interest in marking the impairment, in order to preserve public confidence and uphold standards.

114. The Tribunal considered that imposing a period of suspension on Dr Kleftogianni's registration would send a clear message to the public and members of the profession of what is not acceptable conduct and behaviour for a doctor. On balance, the Tribunal concluded that it was necessary and proportionate to impose a period of suspension.

115. The Tribunal next considered the appropriate period for the suspension. The purpose of the suspension to be imposed was intended to maintain public confidence and uphold standards. Although a breach of fundamental tenet, the harm caused to Patient A, as evidenced, had been at the lower end of scale. The relationship had not been a sexual one and had persisted for a limited period. In the Tribunal's view it was appropriate to impose a relatively short period of suspension. This would mark the misconduct as unacceptable, whilst balancing the suspension with the consideration that this was a doctor who had remediated her misconduct and there was therefore no risk to the public. The Tribunal determined to impose a period of suspension of two months on Dr Kleftogianni's registration to mark the seriousness of her misconduct.

116. Since the Tribunal has imposed the period of suspension on grounds of the public interest alone and it is satisfied that the doctor has remediated her misconduct and does not pose a risk to the public, the Tribunal does not direct that there should be a review in this case.

Erasure

117. The Tribunal accepted both Counsel's submissions that erasure was not the appropriate sanction in this case, taking into account that Dr Kleftogianni had fully remediated her misconduct.

Determination on Immediate Order - 30/07/2020

1. Having determined that Dr Kleftogianni's registration should be suspended, the Tribunal has now considered, in accordance with Section 38 of the Medical Act 1983 as amended, whether to impose an immediate order to suspend his registration.

2. The Tribunal has borne in mind the test to be applied with regard to imposing an immediate order; it may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor.

Submissions

3. Mr Sastry submitted that an immediate order is not necessary.

121. Mr Sheldon also submitted that an immediate order is not necessary.

Tribunal's decision

122. The Tribunal has taken account of the relevant paragraphs of the *SG* in relation to when it is appropriate to impose an immediate order. Paragraph 172 of the *SG* states:

> *"The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor…"*

123. The Tribunal has determined that, in view of its findings on impairment and its determination on sanction, it is not necessary, for the protection of members of the public, to uphold and maintain professional standards, and in the public interest, to make an order suspending Dr Kleftogianni's registration immediately.

124. The substantive decision of suspension, as already announced, will take effect 28 days from when notice is deemed to have been served upon Dr Kleftogianni, unless she lodges an appeal in the interim. If Dr Kleftogianni lodges an appeal, the immediate order for suspension will remain in force until such time as the outcome of any appeal is determined.

125. The current interim order imposed upon Dr Kleftogianni's registration is revoked.

126. That concludes the case.

Confirmed
Date 30 July 2020 Mr Paul Moulder, Chair