Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 18/02/2019 - 01/03/2019
And 17/09/2019 – 19/09/2019

Medical Practitioner’s name: Dr Malcolm LEWIS
GMC reference number: 2490708
Primary medical qualification: MB ChB 1979 University of Manchester
Type of case
New - Misconduct
Outcome on impairment Not Impaired

Summary of outcome
No warning

Tribunal:

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<td>Legally Qualified Chair</td>
<td>Mr Hassan Khan</td>
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<tr>
<td>Lay Tribunal Member:</td>
<td>Mr Keith Moore</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Ranjana Rani</td>
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<td>Tribunal Clerk:</td>
<td>Ms Zaheda Razvi</td>
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Attendance and Representation:

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<td>Medical Practitioner:</td>
<td>Present and represented</td>
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<tr>
<td>Medical Practitioner’s Representative:</td>
<td>Mr Christopher Gillespie, Counsel, instructed by DAC Beachcroft Solicitors</td>
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<tr>
<td>GMC Representative:</td>
<td>Mr Peter Atherton, Counsel, instructed by GMC Legal</td>
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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.
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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 - 01/03/2019
Background

1. At the relevant time of the Allegation, Dr Lewis was a Consultant Paediatric
   Nephrologist at the Royal Manchester Children’s Hospital (RMCH).

2. Between November 2014 and December 2015, Patient A, then aged 13, was under
   Dr Lewis’ care. Patient A had developed a disease affecting her kidneys. Over the
   following months her renal function deteriorated, ultimately resulting in renal failure,
   requiring her to undergo dialysis.

3. In December 2015, Dr Lewis’ nephrology practice was restricted owing to concerns
   raised by the Trust in relation to some aspects of his clinical skills, unrelated to Patient
   A. Although Dr Lewis carried on working at RMCH in the Urology department, Patient A’s
   care was taken over by another team of consultants.

4. Following an investigation by the Trust, in or around April/May 2016, Dr Lewis’
   restrictions on his practice were lifted and he carried on working at RMCH. However, he
   was barred from communicating with his consultant colleagues pending proposed
   remediation for his reintegration into the unit. He resigned from the Trust with a three
   month notice period at the end of April 2016. He was not however re-instated as Patient
   A’s treating consultant nor was he given any responsibility for any aspect of her care.

5. In May 2016, Patient A underwent a kidney transplant, which failed. The kidney
   was donated by her mother, Ms B. Post-operatively Patient A was very unwell due to
   complications and she remained in hospital for some time.

6. It is during this time that Dr Lewis became reacquainted with Ms B, Mr C (Ms B’s
   husband) and Patient A, although the circumstances of the initial contact are disputed.

7. The GMC allegations against Dr Lewis relate to the period following Patient A’s
   failed kidney transplant, between June 2016 and September 2016.

8. In summary the GMC allege that Dr Lewis used his professional position to
   pursue an inappropriate relationship with Ms B by meeting with her regularly,
   sending her Patient A’s blood tests, advising her as to dosages for medication,
   sending sexualised electronic messages, engaging in a facetime call during which he
   appeared to masturbate and sending Patient A a gift. It is alleged that all these acts
were sexually motivated. It is further alleged that Dr Lewis encouraged Ms B to make a complaint about serious events following Patient A’s post-operative period.

The Outcome of Applications Made during the Facts Stage

9. At the end of the GMC’s case an application was made by Dr Lewis’ Counsel, Mr Gillespie, of no case to answer, pursuant to Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’). The Tribunal’s full decision on the application is included at Annex A. As a result of this application a number of the paragraphs of the allegation have been deleted as reflected below.

The Allegation and the Doctor’s Response

10. The Allegation against Dr Lewis is as follows:

1. Between November 2014 and December 2015, you were a consultant responsible for the care of Patient A at Royal Manchester Children’s Hospital (‘RMCH’). Admitted and Found Proved

2. Between June 2016 and September 2016, after you had ceased to be Patient A’s treating consultant, you used your professional position to pursue an inappropriate relationship with Ms B, the mother of Patient A, in that you:

   a. initiated a personal relationship with Ms B by sending a ‘Whatsapp’ message stating that you would be willing to discuss Patient A’s care, or words to that effect; To Be Determined

   b. gained access to Patient A’s blood test reports at RMCH; To Be Determined

   c. conveyed the results of Patient A’s blood test reports, as referred to in paragraph 2 b, to Ms B; To Be Determined

   d. met with Ms B outside RMCH grounds to discuss Patient A’s treatment on one or more occasion; To Be Determined

   e. expressed unfavourable opinions about Patient A’s care and treatment at RMCH, in that you said:

      i. you would have created an arteriovenous fistula before her transplant; Deleted Following a successful Rule 17(2)(g) Application
ii. Patient A should have been given short acting medication to reduce her blood pressure quickly to prevent the seizures which had occurred; or words to that effect; **To Be Determined**

f. advised Ms B on the dosages of Patient A’s medications of:
   i. Frusemide; **To Be Determined**
   ii. Tacrolimus; **To Be Determined**

g. sent electronic messages to Ms B, in which you:
   i. stated you had always loved her or words to that effect; **To Be Determined**
   ii. stated that you wished Patient A was your child or words to that effect; **To Be Determined**
   iii. used sexualised language; **To Be Determined**

h. engaged in a ‘facetime’ call with Ms B in September 2016 during which you appeared to masturbate under the bedclothes; **Deleted Following a successful Rule 17(2)(g) Application**
   i. sent a gift for Patient A to her home address. **To Be Determined**

3. Your actions at paragraphs 2a and/or 2b and/or 2c and/or 2d and/or 2ei and/ 2eii and /or 2f and/or 2gi and/or 2gii and/or 2giii and/or 2h and/or 2i were sexually motivated. **To Be Determined**

4. Your advice to Ms B, described at paragraph 2(f), was also inappropriate, as you failed to:
   a. disclose this advice to Patient A’s treating consultants; **To Be Determined**
   b. make any clinical record of this advice. **To Be Determined**
5. With malicious intent for your former colleagues at RMCH you sought to persuade Patient A’s parents to make a formal complaint about Patient A’s treatment. **To Be Determined**

**The Admitted Facts**

11. At the outset of these proceedings, through his counsel, Mr Gillespie, Dr Lewis made an admission to paragraph 1 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 this paragraph as admitted and found proved.

**Factual Witness Evidence**

12. The Tribunal received the following witness evidence:

- Witness Statement of Professor D dated 2 May 2018;
- Witness Statement of Professor E dated 4 May 2018;
- Witness Statement of Ms B dated 31 May 2018 and Supplementary Witness Statement dated 31 May 2018;
- Witness Statement of Mr BO (referred to in confidentiality key as Mr C) dated 6 June 2018 and further Witness Statement dated 28 October 2018;
- Witness Statement of Dr F dated 8 June 2018; and

13. The Tribunal heard oral evidence from the following GMC witnesses:

- Mr C (Patient A’s father);
- Ms B (Patient A’s mother);
- Mr F;
- Professor D;
- Professor E; and
- Dr H, Expert witness.

14. Dr Lewis provided his own witness statement dated 31 December 2018 and gave oral evidence at the hearing.

15. Dr Lewis also relied on three character witnesses, to support his good character, who were not called to give oral evidence.

- Dr G
- Reverend I
- Mrs J

**Documentary Evidence**
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16. The Tribunal had regard to a separate bundle of exhibits, Patient A’s medical records and IT policy related documents consisting of 2039 pages. The Tribunal also had regard to several additional documents produced by Dr Lewis.

SUBMISSIONS OF COUNSEL

On Behalf of the GMC

17. Mr Atherton reminded the Tribunal that the events occurred during a time when there was a lack of equilibrium in the lives of those involved. Following serious challenges to his reputation, Dr Lewis was planning a significant career change and a move to Ireland. Ms B was dealing with the aftermath of her daughter’s failed kidney transplant and her deteriorating health. Despite this, he said that Dr Lewis had a distorted sense of propriety and lack of awareness of professional boundaries in his dealings with Ms B.

18. He submitted that Ms B gave her evidence in a calm manner, and although reticent at times, did not exaggerate or demonstrate any irrational hostility towards Dr Lewis.

19. Mr Atherton submitted that a key point was that from December 2015, Dr Lewis ceased to have any clinical responsibilities for Patient A and his practice was restricted by the Trust. He said that it was reasonable to infer that making contact with Ms B was calculated and discussing Patient A’s care could be seen as an act of defiance on his part.

20. As to the seriousness of Dr Lewis’ actions, he submitted that Dr Lewis’ actions were not isolated. He suggested they involved a sustained communication with Ms B which was unwise against the background of his troubled relationship with the Trust.

21. Mr Atherton submitted that Dr Lewis planned to embark on a physical relationship with Ms B, although he accepted such a relationship was not established.

22. Mr Atherton submitted that the contemporaneous emails between Mr C and Ms B provided strong evidence that there was a secretive relationship between Ms B and Dr Lewis and it was more than a superficial friendship.

23. Mr Atherton accepted that aspects of Mr C’s evidence and behaviour were concerning. He described him as volatile, angry and capable of making ill-judgments, all of which supported the evidence that he was insecure.

24. Mr Atherton concluded his submissions by suggesting that the Tribunal could properly and fairly infer and conclude that this was a classic case of grooming of a vulnerable female for the purposes of pursuing a sexual relationship.
On Behalf of Dr Lewis

25. Mr Gillespie submitted that in this case credibility is “indivisible” and that the words of the charge need to be given their full effect. He submitted the definition of sexual motivation is clear. He reminded the Tribunal that the more serious the allegation the more cogent the evidence must be.

26. Mr Gillespie said that Dr Lewis was unlikely to act in a way that could be detrimental to Patient A. He said he was a man who has dedicated his life to treating sick children, his patients adore him and he would not take any step to endanger a child’s health, which included establishing a personal relationship with Ms B.

27. Mr Gillespie rejected the question posed by Mr Atherton in his submission, namely: ‘Why would Ms B make up this allegation’ if not true. He said this ignores the fact that the allegation, in reality, is made by Mr C. He described Mr C as a liar, bully and a thug. He added that Mr C’s behaviour was manipulative following his assault on Ms B, as he played the role of victim by turning on Ms B and accusing her of a physical affair and making a complaint to the Trust.

28. Mr Gillespie emphasised that Mr C was the instigator of the complaint to the Trust which ultimately led to the GMC referral. He said that despite Mr C infrequently attending appointments with Patient A and therefore only meeting Dr Lewis on a limited number of occasions, he was convinced Ms B wanted or was having an affair with him. He submitted that this was an idea he had for some time as a jealous man with fixed ideas.

29. He said that Mr C’s credibility was significantly undermined by him repeatedly ignoring GMC requests to produce the text messages, his unlikely reasons for claiming privilege and his false story that his laptop had been stolen.

30. As to Ms B’s evidence, Mr Gillespie submitted that there was a complete failure by her to describe any of the text messages, despite opportunities to do so and as a consequence, the Tribunal had no evidence of the content of them. The effect of this was that the Tribunal had no reliable or cogent evidence to reach the conclusion that anything inappropriate was said within those messages.

31. Mr Gillespie submitted that it was clear that Dr Lewis was unhappy with his former colleagues in relation to the previous investigation, but that it did not follow that he would instigate a complaint against them through Ms B or Mr C.

32. Mr Gillespie submitted that Dr Lewis accepted that he accessed Patient A’s records but that there was nothing sinister in this as he had Ms B’s consent and there was no breach of confidentiality.
Mr Gillespie concluded his submissions by reminding the Tribunal that Dr Lewis is a man of good character. He said he "is a thoroughly decent doctor who was caught in the cross-fire of a collapsing marriage between Mr C and Ms B".

The Tribunal’s Approach

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

The Tribunal reminded itself of the well-established case-law of Re H (Minors) (Sexual Abuse: Standard of Proof) [1996] AC 563 and Re B (Children) [2008] UKHL 35 which makes clear that “the more serious the allegation the less likely it is that the event occurred, and thus the stronger and more cogent should be the evidence before a court determines that on the balance of probabilities, the event did occur.”

The Tribunal also accepted advice from the Legally Qualified Chair (LQC) that this did not affect the standard of proof, namely the balance of probabilities.

The LQC also made reference to Basson v General Medical Council [2018] EWHC 505 namely that “sexual motive means that the conduct was done either in pursuit of sexual gratification or in pursuit of a future sexual relationship”.

In relation to expert evidence, the LQC indicated that expert evidence is admitted on matters that lie beyond the common experience and understanding of the Tribunal. Mr H has provided evidence on two matters. The appropriateness of Dr Lewis’ actions and whether those actions fell below or seriously below the standards expected. He indicated that appropriateness is a matter for the Tribunal's judgment, having heard all the evidence in this case. In any event, he said that, where an expert has given opinion evidence, the Tribunal remained the ultimate arbiters of the matters about which the expert had testified and were not bound to accept the expert’s opinion, if there was a proper basis for rejecting it.

On the invitation of the parties, the LQC provided a complete good character direction.

The Tribunal’s Analysis of the Evidence and Findings

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

Mr C (Ms B’s husband) gave evidence in person. The Tribunal did not find him to be a credible witness and his evidence could not be relied on, for several reasons:
- The Tribunal did not consider that he gave frank evidence. For example, he often answered questions with questions, was not straightforward in his replies, often adding unnecessary and irrelevant detail and attempted to obfuscate and avoid the questions asked.

- The Tribunal considered the email exchanges between Mr C and Ms B to be very concerning and depicted Mr C as a man who was angry, controlling and insecure, convinced that Ms B was having a physical affair, despite her protestations.

- The Tribunal considered that Mr C lied to the Tribunal when he said that he did not report to Professor D that his wife sustained a black eye after he assaulted her in August 2016. Professor D said that he remembers the conversation which took place on 17 September 2016 ‘with absolute clarity’ and confirmed this in his oral evidence. The Tribunal preferred Professor D’s evidence on this point.

- The Tribunal considered that Mr C’s credibility was significantly undermined by his failure to comply with the requests by the GMC to produce the messages. This was despite being given several opportunities and the threat of court enforcement action against him. Further, the Tribunal found the whole chain of events regarding his reasons for non-disclosure of the messages and those surrounding the theft of his laptop to be wholly incredible. In particular, his claims that he was advised not to disclose the messages to avoid self-incrimination were improbable as there was no evidence that he had in fact received such advice. In any event he had filed a sworn witness statement in which he conceded that he had downloaded the messages, and thereby amounting to an admission as to possible criminal conduct.

42. Ms B (Patient A’s mother) gave evidence via a video-link. The Tribunal found her to be credible in general, but considered her to be an unreliable historian as to her recollection of events, their sequence and relevant dates. Importantly, she was simply unable or unprepared to state what was contained in the alleged sexualised text messages. She was also mistaken about important matters. For example, she was insistent that she had never altered the tacrolimus dose for Patient A, when there was clear documentary evidence that she had. The Tribunal also found that she minimised Mr C’s behaviour, for example by saying she should not have involved the police, despite Mr C’s assault upon her resulting in her sustaining a burst eardrum. In her documentary evidence and in her oral evidence she appeared to shoulder the burden of responsibility for the breakdown of the marriage.

43. The Tribunal considered that the evidence of Professor D, Professor E, Mr F and Dr H were consistent with their written evidence. They were called for the
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purposes of clarification rather than challenge to their evidence. Dr H accepted that
his opinions may vary depending on the findings of the Tribunal.

44. Dr Malcolm Adrian Lewis gave evidence in person. The Tribunal found him to
be a credible witness. He accepted elements of the charges but remained consistent
that his actions were not inappropriate. The Tribunal found that he gave careful and
considered responses to the questions put to him. However, the Tribunal found Dr
Lewis less convincing in his responses to Tribunal questions. In particular, he did not
provide satisfactory explanations as to the appropriateness of maintaining a
friendship with a parent of a patient, when he was not the treating consultant, nor
was he able to explain why Ms B or Patient A’s circumstances were so exceptional to
cause him to behave differently, than he would have done with any other parent or
patient.

Paragraph 2

45. The Tribunal carefully considered the wording of the stem of paragraph 2,
namely that "after you had ceased to be Patient A’s treating consultant, you used
your professional position to pursue an inappropriate relationship with Ms B."

46. In June 2016 Dr Lewis became reacquainted with Ms B, Mr C and Patient A.
He knew the family as he had previously been the treating consultant for Patient A
for around 12 months prior to December 2015. It is clear by June 2016, Dr Lewis
was no longer the treating consultant for Patient A and around 6 months had
elapsed since he was last responsible for her care. In the intervening period Dr
Lewis had been engaged in a dispute with his consultant colleagues who took over
the care of Patient A. On any view, Dr Lewis had no clinical responsibility for Patient
A’s care at the time of the Allegation.

47. Further, the Tribunal noted that Ms B and Patient A were vulnerable. Patient
A had recently undergone a failed kidney transplant, with her mother, Ms B being
the donor. Following this traumatic event, Ms B was dissatisfied with the care being
provided to her daughter by the treating clinicians, in the light of the handling of a
series of complications in her condition. Between June 2016 and September 2016 Dr
Lewis provided covertly advice and assistance in relation to the decisions that were
being made by Patient A’s treating consultants. There was a real risk that Dr Lewis’
advice or assistance could undermine and directly impact on the care being provided
to her, particularly as Dr Lewis was aware that treating consultants had previously
viewed Ms B as ‘difficult’. The Tribunal noted the testimonial evidence on behalf of
Dr Lewis suggesting that he routinely provided patients with his personal details at
the outset to the parents of seriously ill patients. This however related to patients
formally under his care and should not have been continued in Patient A’s case, as
she was no longer his patient and there had been a dispute between Dr Lewis and
Patient A’s treating consultants.
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48. For all these reasons, the Tribunal considered that it was wholly inappropriate for Dr Lewis to start and carry on meeting and advising Ms B, whether based on friendship or otherwise.

Paragraphs 2(b), 2(c), 2(d) and 2(i)

49. Dr Lewis has admitted the following sub-paragraphs but denies that his actions were inappropriate:

- 2(b) gained access to Patient A’s blood test reports at RMCH;
- 2(c) conveyed the results of Patient A’s blood test reports, as referred to in paragraph 2b, to Ms B;
- 2(d) met with Ms B outside RMCH grounds to discuss Patient A’s treatment on one or more occasion;
- 2(i) sent a gift to Patient A to her home address.

50. The Tribunal relied on its findings set out under paragraph 2. It considered that Dr Lewis’ actions, taken individually or cumulatively, were inappropriate. Dr Lewis was not the treating consultant at the relevant time, Ms B was vulnerable given the recent traumatic events of Patient A’s failed kidney transplant, and a conflict of interest existed because of a dispute between Dr Lewis and Patient A’s treating consultants.

51. The Tribunal further finds that Dr Lewis was an experienced consultant and should have been aware of the professional boundaries required of him, particularly in the circumstances of this case. All of the actions taken by Dr Lewis fell outside his professional responsibilities at the time.

52. Accordingly, the Tribunal finds these paragraphs proved.

Paragraph 2(a)

53. It is alleged that Dr Lewis “initiated a personal relationship with Ms B by sending a ‘Whatsapp’ message stating that you would be willing to discuss Patient A’s care, or words to that effect.”

54. Ms B’s evidence was that after passing Dr Lewis in the hospital corridor, she received a Whatsapp message from Dr Lewis in June 2016, suggesting that Dr Lewis had heard that Patient A was not well and asked whether Ms B wanted to meet him to talk. Ms B gave a similar account at the Trust’s meeting with her and she maintained her account in her oral evidence.

55. Dr Lewis denied that he initiated the contact. He said that he had bumped into Ms B in the corridor as Patient A was undergoing dialysis at RMCH three times per week. He said that Ms B expressed concerns as to whether Patient A was
receiving the appropriate level of care. He said that following this he and Ms B went to discuss Patient A over coffee, just outside the hospital.

56. The Tribunal considered that it was more likely than not that the interactions between Dr Lewis and Ms B started when they bumped into one another in the RMCH corridor. In oral evidence, Ms B accepted that there was an occasion in June 2016 when this happened. The Tribunal also considers that it is likely that, at this time, since Patient A was receiving dialysis three times a week, there were many opportunities for Ms B and Dr Lewis to have coincided at the hospital.

57. Further, in making its findings, the Tribunal also took into account the fact that it had no documentary evidence of the message, there was no mention of the message in any of the email communications between Ms B and her husband and there was no reference to it in Mr C's evidence. The only documentary evidence of a Whatsapp communication passing between Dr Lewis and Ms B was in 2017, which was instigated by Ms B.

58. In all the circumstances the Tribunal considered that it was more likely than not, that the meetings between Ms B and Dr Lewis started and evolved through hospital interactions when Patient A was attending for dialysis and/or other post-operative care.

59. Accordingly, the Tribunal found paragraph 2(a) not proved.

Paragraph 2(e)(i)

60. Paragraph 2(e)(i) was deleted following a successful Rule 17(2)(g) application

Paragraph 2(e)(ii)

61. It is alleged that Dr Lewis “expressed unfavourable opinions about Patient A’s care and treatment at RMCH, in that you said that Patient A should have been given short acting medication to reduce her blood pressure quickly to prevent the seizures which had occurred or words to that effect”

62. Ms B’s evidence was that Dr Lewis commented that Patient A’s seizures following her transplant could have been avoided if she had different medication, and it was a ‘stupid’ decision to give her long acting medication. Ms B said she knew that Patient A should have been given a short acting medication to bring her blood pressure right down quickly and prevent a seizure. She said she thought Dr Lewis was ‘pointing out the obvious’. She further stated that Dr Lewis undermined the other doctors at RMCH and phrased his messages along the lines that ‘if I were treating Patient A, I would do this’. She said that ‘having reflected on the way these
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messages were put, I feel as though Dr Lewis was angry with RMCH and bitter about the internal investigation and was channelling this anger about this through Patient A, by criticising how the consultants at RMCH were treating Patient A.’

63. Dr Lewis’ case is that the worst thing he could have done was to undermine the confidence of Ms B in the team looking after them, which he also confirmed in his letter to Professor E. Dr Lewis said that his intention was only to reassure Ms B, and far from suggesting that the actions of the consultants was a stupid idea, he said he would have done the same thing as them.

64. The Tribunal did not consider that Dr Lewis expressed unfavourable opinions in relation to the issue of whether Patient A should have been given short acting medication post-transplant. The Tribunal considers that it is more likely than not that Ms B misinterpreted Dr Lewis’ expression of options as criticisms. Even in her own evidence she suggested that Dr Lewis was ‘pointing out the obvious.’ More importantly it appears from Ms B’s allegation that Dr Lewis was being critical of the treating consultants ‘having reflected on the way these messages were put.’ This indicates that not only was Ms B giving evidence in hindsight, but she was also interpreting messages she did not have access to at the time she made her statement. Further the Tribunal does not have any documentary evidence in support of the messages.

65. The Tribunal also accepted that Dr Lewis would not do anything to jeopardise Patient A’s care which was confirmed by Ms B in her oral evidence.

66. In all these circumstances, the Tribunal found paragraph 2(e)(ii) not proved.

Paragraph 2(f)(i)

67. It is alleged that Dr Lewis “advised Ms B on the dosages of Patient A’s medications of Frusemide.”

68. Ms B’s evidence was that she told the Trust meeting in October 2016 that Dr Lewis advised as to the dosage of frusemide. She said that she asked Patient A to directly contact Dr Lewis via text message with her weight and blood pressure which was a bit like having an online consultant. Dr Lewis would respond with the appropriate dose. Ms B said that she was happy with this, as the treating consultant had given her this leeway.

69. Dr Lewis’ evidence was that Patient A had been given a variable dose range for frusemide, to be adjusted according to her weight and blood pressure. He said that Ms B and Patient A sometimes asked him for his thoughts on the dosage within the range when parameters conflicted, i.e. BP high but weight not raised. He said that he was merely seeking to reassure Ms B and Patient A with choosing the correct dose of frusemide within a range given to them by RMCH.
The Tribunal considered that it was more likely than not that Dr Lewis’ offered advice as to the appropriate dose of frusemide, albeit that he was doing so within a range given by RMCH. The Tribunal considered that the evidence given by Ms B to the Trust meeting was credible and the likelihood was that either Ms B or Patient A would provide Patient A’s weight and BP, and Dr Lewis would suggest the appropriate dose. The Tribunal makes it clear that there is no evidence to suggest that Dr Lewis advised of a dosage which fell outside the range recommended by the treating consultants. This was confirmed by Mr H, the GMC expert.

Accordingly the Tribunal found paragraphs 2(f)(i) proved.

Paragraph 2(f)(ii)

It is alleged that Dr Lewis “advised Ms B on the dosages of Patient A’s medications of Tacrolimus (Tac).” The Tribunal was informed that this was an antirejection treatment and it was vital that the dosages were correct.

Ms B suggested that Dr Lewis advised at the relevant Tac doses. She said that Patient A was sensitive to Tac, as it would affect her blood pressure. However, she also made clear that she would never change Patient A’s Tac levels, irrespective of whether Dr Lewis would have advised of an alternative Tac dose. This was inconsistent with the documentary evidence when she had altered the dose on one occasion.

Dr Lewis said that Ms B was fixated on the idea that Patient A was sensitive to Tacrolimus. He said he tried to reassure her that the dose was appropriate, or that the dose would be adjusted at the next hospital visit based on the blood levels of Tac. In his oral evidence Dr Lewis said that Ms B had some insecurity about making the decision so he helped her as they were logical decisions. He said Ms B had an obsessive concern with Tac levels as she felt Patient A was sensitive to it.

Dr Lewis told the Tribunal that it was rare for the Tac levels to drift lower than 5. He added that he would never have suggested a change as the levels were absolutely fine. He said he wasn’t responsible for her care, was merely trying to help the mother to ‘see through the mist.’ He said he had devoted 40 years in looking after children and would never compromise the care of a child.

It was common ground that Ms B was highly anxious about Tac levels as she considered Patient A to be highly sensitive to Tac levels. The Tribunal considers it more likely than not, that she sought guidance from Dr Lewis as to those levels. The Tribunal accepted that Dr Lewis sought to provide Ms B with reassurance in relation to her concerns but did not specifically advise as to dosages in the same way as he advised in relation to frusemide. Given the critical importance of its correct administration and the acceptance by Ms B that Dr Lewis would not compromise
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Patient A’s care, the Tribunal considers it more likely than not that Dr Lewis did not advise as to Tac doses.

77. In any event the Tribunal considered that Ms B was well educated on the topic of the administration of Tac and was likely to challenge any decision to alter Patient A’s dosage, irrespective of any advice, given her acute anxiety that Patient A was sensitive to it.

78. Taking all these matters into account the Tribunal found paragraph 2(f)(ii) not proved.

Paragraph 2(g)(i)

79. It is alleged that Dr Lewis sent electronic messages to Ms B, which stated he had always loved her or words to that effect.

80. Ms B’s evidence was that in July or August 2016 she received an odd message from Dr Lewis in the evening. She said he had been at his leaver’s party that evening and sent the message after some drinks. She said that she thought the message was weird but took it light heartedly. She said she had become good friends with Dr Lewis and she was not going to let the message affect their friendship. She said she was flattered to receive the message and that she probably responded to the message but she could not remember what she said.

81. Dr Lewis categorically denied sending such a message. He said he attended the leavers party and cycled home and that he does not drink and cycle. When asked if he loved Ms B, he responded “she was a nice person, I felt sorry for her but that was it”.

82. The Tribunal did not consider there to be cogent evidence as to whether Dr Lewis sent an electronic message to Ms B saying that he had always loved her.

83. The Tribunal does not have the benefit of any evidence of the message itself and no person was able to confirm precisely what it said. Ms B was vague when asked about this in cross examination and the Tribunal was troubled that she could not recall the contents of a message with more precision, given that it is said to have ultimately led to the demise of her marriage.

84. The Tribunal also gave careful consideration to the contemporaneous email communication between Ms B and Mr C and considered that the messages raised more questions than they answered. It was difficult to interpret the messages from Ms B and responses to them (and vice-versa). In addition, the Tribunal was mindful that the messages were exchanged between Ms B and Mr C at a time of heightened emotions and their exchanges could not provide reliable evidence as to the issues this Tribunal was required to determine. The Tribunal was also mindful of its earlier
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findings in respect of Mr C’s credibility, and given his great insecurities, his obsession with Ms B having a physical affair, irrespective of the reality, he was likely to misinterpret any messages he saw.

85. In light of all these factors, the Tribunal found paragraph 2(g)(i) not proved.

In relation to 2(g)(ii)

86. It is alleged that Dr Lewis sent electronic messages to Ms B, which stated that he wished Patient A was his child or words to that effect.

87. Ms B’s evidence was that when she received this message she ignored it and never challenged Dr Lewis as to why he sent it. In oral evidence she said that she could not back up her assertions but that Dr Lewis did send her the message.

88. The Tribunal did not consider there to be cogent evidence as to whether Dr Lewis sent this message.

89. Once again the Tribunal did not have any evidence of the message itself. There was no reference to this message by Ms B when she spoke to the Trust during their investigation. She raised it for the first time in her witness statement made on 31 May 2018 when she did not have the benefit of the message being in her possession as it had long since been deleted.

90. Further, the Tribunal also noted that there was no discussion of this message between Ms B and Mr C in the contemporaneous email communications between them.

91. Having regard to the above, the Tribunal found paragraph 2(g)(ii) not proved.

In relation to 2(g)(iii)

92. It is alleged that Dr Lewis sent electronic messages to Ms B, in which he used sexualised language.

93. Ms B said that the messages between her and Dr Lewis progressed to the point where they were exchanging sexual messages, or ‘sexting’, on a daily basis. She said she was flattered by this attention She said her relationship could be classed as a cyber affair but she was not interested in having a physical affair with Dr Lewis. In oral evidence Ms B was pressed as to what the messages said. Her response was “I don’t really want to go into that.” When pressed further she elaborated “it was just a lot of sexual innuendos – if we ever got together what would happen – what we would do.” Ms B said that there were over a thousand messages.
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94. Mr C said that he had access to and downloaded the alleged sexualised messages. Mr C did not provide evidence of the messages when he had a meeting with Professor D nor did he show them to Dr F. Both confirmed in oral evidence that Mr C had the opportunity to provide those messages but he failed to do so.

95. Dr Lewis denied that he sent any sexualised messages. He told the Tribunal “I have been married for 37 years. During this time my marriage was absolutely fine. I was not looking for an affair. I had no inkling and no opportunity anyway.”

96. The Tribunal was unable to assess whether the messages themselves were sexualised as evidence of the actual texts were not available to the Tribunal. It is regrettable that both Ms B and Dr Lewis have deleted these messages. Furthermore, Mr C, who initiated the referral against Dr Lewis suggested that he no longer had those messages after he says his laptop, containing the messages, was stolen.

97. In the absence of these messages there is a direct conflict of evidence between Dr Lewis, Ms B and Mr C. Ms B simply refused to provide any information as to the content of the messages, despite being provided with numerous opportunities, and when pressed, her oral evidence was vague. Mr C’s evidence, given the credibility findings made against him, carried minimal weight.

98. In light of all these circumstances, the GMC has failed to provide cogent evidence, sufficient to discharge the burden of proof, on the balance of probabilities, that the texts contained sexualised language.

99. Accordingly, the Tribunal found paragraph 2(g)(iii) not proved.

Paragraph 2(h)

100. This paragraph was deleted following a successful Rule 17(2)(g) application

Paragraph 3

101. It is alleged that Dr Lewis’ actions at paragraphs 2a and/or 2b and/or 2c and/or 2d and/or 2ei and/ 2eiI and /or 2fi and/or 2fii and/or 2g and/or 2gii and/or 2giiI and/or 2h and/or 2i were sexually motivated.

102. The Tribunal has already determined that there was no case to answer in respect of sub-paragraphs 2(e)(i) and 2(h). It follows that paragraph 3 as it relates to these paragraphs falls.

103. The Tribunal has further found that the electronic messages, including the ‘sexting’ allegations set out within sub-paragraphs 2(g)(i)(ii)(iii) are found not proved. It follows that paragraph 3 as it relates to these paragraphs falls.
104. The Tribunal has also found paragraph 2(e)(ii) and 2(f)(ii) not proved. It follows that paragraph 3 as it relates to these paragraphs falls.

105. The Tribunal reminded itself that for an act to be sexually motivated it must be in pursuit of sexual gratification or in pursuit of a future sexual relationship.

106. In light of the Tribunal’s findings in respect of paragraph 2, the submission of the GMC is rejected, namely the actions of Dr Lewis contained within 2(a), 2(b), 2(c), 2(d), 2(e)(ii), 2(f)(i) and 2(i) was a course of conduct aimed at grooming Ms B to having a sexual relationship with him.

107. The Tribunal has found that Dr Lewis’ actions were clearly inappropriate, but the Tribunal, applying the appropriate test, did not consider there to be a sexual element to these allegations, whether in pursuit of sexual gratification or in pursuit of a future sexual relationship.

108. Having regard to the above, the Tribunal found paragraph 3 in relation to paragraphs 2a, 2b, 2c, 2d, 2f(i) or 2i, not proved. Therefore paragraph 3 is found not proved in its entirety.

**Paragraph 4(a) and (b)**

109. It is alleged that Dr Lewis’ advice to Ms B, described at paragraph 2(f), was also inappropriate, as he failed to:

   a. disclose this advice to Patient A’s treating consultants
   b. make any clinical record of this advice.

110. The Tribunal has found 2(f)(ii) not proved. It follows that 4(a) and 4(b) in relation to 2(f)(ii) falls.

111. The outstanding allegation the Tribunal must consider is 2(f)(i) since this allegation was found proved.

112. In relation to 4(a) the Tribunal considered that there was a duty on Dr Lewis to disclose his advice to Patient A’s treating consultants irrespective of whether the advice as to frusemide dosage was given with an acceptable range. The GMC expert, Dr H in oral evidence said “there was still a need to record the advice, even if the advice was do nothing.”

113. In reaching its decision the Tribunal considered the unique circumstances of this case in that Dr Lewis had been the previous treating consultant, that he was no longer assigned to Patient A’s care and he had been engaged in a dispute with
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Patient A’s current treating consultants and his awareness of the difficult relationship that had existed between Ms B and the treating consultants. The Tribunal considered that this imposed an additional burden on him to be open with the treating consultants if he was proffering advice to one of their patients. That obligation existed despite the restriction on his communication with the treating consultants, as other avenues of communication could be utilised.

114. The Tribunal also took account of the following paragraphs of Good Medical Practice.

"16. In providing clinical care you must:

d. consult colleagues where appropriate

21. Clinical records should include:

c. the information given to patients"

115. Having found that a duty existed, the Tribunal finds that Dr Lewis breached this duty by failing to inform Patient A’s treating consultants of the advice he gave.

116. Accordingly, the Tribunal found paragraph 4(a) as it relates to 2(f)(i) proved.

117. In relation to 4(b) the Tribunal considered that no duty arose for Dr Lewis to make a clinical record of his advice on the dosage of frusemide, since the appropriate dosage had already been recommended by Patient A’s treating consultants. The advice given by Dr Lewis was within the range recommended. Accordingly, the Tribunal found paragraph 4(b) as it relates to 2(f)(i) not proved.

Paragraph 5

118. It is alleged that Dr Lewis, with malicious intent for his former colleagues at RMCH, sought to persuade Patient A’s parents to make a formal complaint about Patient A’s treatment.

119. The Tribunal reminded itself that this charge could only be proved if the Tribunal found there to be malicious intent towards Dr Lewis’s former colleagues and that he sought to persuade Patient A’s parents to make a formal complaint.

120. Mr C and/or Ms B drafted a formal complaint in August 2016. When Ms B was cross examined she accepted that Dr Lewis had no input into the contents of that draft and the complaints eventually submitted in December 2016 were her own and not attributable to any influence from Dr Lewis.

121. The Tribunal noted the inconsistency in the evidence of Ms B and Mr C in the context of a meeting with Dr Lewis at their home in July 2016. Mr C stated that
during the meeting Dr Lewis spoke at length about the issues he had with his former colleagues and encouraged them to make a complaint. Ms B contradicted this evidence and suggested that the discussion only centred around Patient A’s care, although in oral evidence she resiled from this view.

122. Dr Lewis’ evidence was that he was not critical of his colleagues to Ms B or Mr C and did not incite them to make a complaint against them. He said that his frustration may have shown through however when he met with Ms B and Mr C. In his letter to Professor E he said ‘I have not incited the families to make complaints or impugned the reputation of colleagues as I recognise the need for the families to maintain confidence in the teams looking after them. ... She had personal problems with a number of the consultant team and I reassured her that whilst she had good relationship with me, all other team members were adequately trained’. In oral evidence Dr Lewis said “at the time I did have personal difficulties with those consultants – I tried my best not to put across my dealings – if they did come across I sincerely regret that as it was not my intention.”

123. The Tribunal preferred the evidence of Dr Lewis to that of Mr C and Ms B. The Tribunal considered that it was more likely than not, that Dr Lewis may have allowed his frustrations to surface at the meeting with the family in July 2016, his behaviour fell far short of any malicious intent towards his colleagues or was in any way designed to incite a complaint against his former colleagues. In reaching this decision the Tribunal accepted Dr Lewis’ evidence, that although there was a dispute between him and his consultant colleagues he did not seek to embroil Mr C and Ms B within it. The Tribunal considered that it was more likely that Mr C and Ms B had their own concerns in relation to the care provided to Patient A following her transplant which they accepted they accurately set out in their complaint sent in December 2016.

124. Accordingly, the Tribunal found paragraph 5 not proved.

The Tribunal’s Overall Determination on the Facts

125. The Tribunal has determined the facts as follows:

1. Between November 2014 and December 2015, you were a consultant responsible for the care of Patient A at Royal Manchester Children’s Hospital (‘RMCH’). Admitted and Found Proved

2. Between June 2016 and September 2016, after you had ceased to be Patient A’s treating consultant, you used your professional position to pursue an inappropriate relationship with Ms B, the mother of Patient A, in that you:
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a. initiated a personal relationship with Ms B by sending a ‘Whatsapp’
   message stating that you would be willing to discuss Patient A’s care,
   or words to that effect; Found Not Proved

b. gained access to Patient A’s blood test reports at RMCH; Found
   Proved

c. conveyed the results of Patient A’s blood test reports, as referred to in
   paragraph 2 b, to Ms B; Found Proved

d. met with Ms B outside RMCH grounds to discuss Patient A’s treatment
   on one or more occasion; Found Proved

e. expressed unfavourable opinions about Patient A’s care and treatment
   at RMCH, in that you said:

   i. you would have created an arteriovenous fistula before her
      transplant; Deleted Following a successful Rule 17(2)(g) Application

   ii. Patient A should have been given short acting medication to
       reduce her blood pressure quickly to prevent the seizures which
       had occurred;

       or words to that effect; Found Not Proved

f. advised Ms B on the dosages of Patient A’s medications of:

   i. Frusemide; Found Proved

   ii. Tacrolimus; Found Not Proved

g. sent electronic messages to Ms B, in which you:

   i. stated you had always loved her or words to that effect; Found
      Not Proved

   ii. stated that you wished Patient A was your child or words to that
       effect; Found Not Proved

   iii. used sexualised language; Found Not Proved

h. engaged in a ‘facetime’ call with Ms B in September 2016 during which
   you appeared to masturbate under the bedclothes; Deleted
   Following a successful Rule 17(2)(g) Application

   i. sent a gift for Patient A to her home address. Found Proved
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3. Your actions at paragraphs 2a and/or 2b and/or 2c and/or 2d and/or 2e and/or 2f and/or 2gi and/or 2gii and/or 2giii and/or 2h and/or 2i were sexually motivated. Found Not Proved in its entirety

4. Your advice to Ms B, described at paragraph 2(f), was also inappropriate, as you failed to:
   a. disclose this advice to Patient A’s treating consultants; Found Proved
   b. make any clinical record of this advice. Found Not Proved

5. With malicious intent for your former colleagues at RMCH you sought to persuade Patient A’s parents to make a formal complaint about Patient A’s treatment. Found Not Proved

Determination on Impairment - 19/09/2019

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts found proved, Dr Lewis’s fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, and the supplementary bundle adduced at this stage, which included the following:

   • Unsolicited reference from a member of the public;
   • References from families treated by Dr Lewis;
   • Certificates of courses attended;
   • Dr Lewis’s Structured Reflection documents, dated February and September 2019;
   • Bundle of cards from patients and colleagues from his retirement in 2016; and
   • Video clip of retirement presentation.

3. In his first reflective statement dated February 2019, prepared before the Tribunal handed down its determination on the facts, Dr Lewis provided background, the context of his position and his feelings at the time of the events in 2016. He then provided an evaluation and analysis in which he stated:

   'Over my 26 year consultant career I had experienced no previous problems regarding Doctor/Patient/Parent relationships. Whilst working as a consultant I had never allowed boundaries to blur – even though I have close contact with families and allowed those with life threatening disease to have direct
contact. In retrospect, my emotional state following the allegations by my colleagues against me, severely clouded my judgement. I allowed my desire to improve the care for Patient A to blind me to the fact that any involvement was inappropriate as I was no longer the treating physician. By allowing boundaries to become blurred and acting as a friend I opened the door to Ms B to talk about diverse matters outside the scope of the previous doctor/patient/parent relationship.

I have learned a lot from this experience. I recognise that my behaviour under these circumstances had the potential to impact not only Ms B, but also my colleagues at RMCH. Due to the circumstances at this time, I felt I was unable to communicate my actions and concerns to my colleagues. I can now clearly see the potential consequences of inadequate or absent communication. This has highlighted the importance of maintaining professional boundaries, inter-professional communication and a supportive work environment’.

4. Dr Lewis, in conclusion stated:

‘I deeply regret;

- Allowing my judgement to be clouded by the events leading to my resignation from RMCH.
- Allowing the development of a “relationship” between Ms B and myself where the boundaries between friendship and a professional relationship were not clear in her eyes.
- Allowing Ms B to become dependent on me when I was not in a position to help professionally.

I accept full responsibility for my conduct and acknowledge that I should have handled the situation differently. Had I ended the contact with Ms B at an early stage, subsequent events could have been avoided.’

5. Dr Lewis also provided an action plan and stated that he was committed to undertake all necessary steps to ensure that he would not make any of these mistakes in the future. He also indicated that he appreciated the need to be absolutely clear where professional boundaries lie and, in future, avoiding factors that could blur professional boundaries.

6. In his second reflective statement, dated September 2019, in response to the Tribunal’s findings, Dr Lewis confirmed that he accepted all of the criticisms made of him. He stated:

‘Since the conclusion of the first stage of the hearing, I have had considerable time to reflect further upon issues that were raised during the hearing and examine my own thoughts, feelings and behaviour. When I gave evidence,
Counsel for the GMC embarked upon a lengthy and accusatory line of questioning. I found this process difficult and traumatic as I had to simultaneously strongly defend myself against the false accusations being made against me, whilst also considering aspects of my behaviour at the time of the incidents that were more questionable.

... I now recognise that my actions had the potential to undermine the care of Patient A and understand that my communication with this family, however well intentioned, was inappropriate as I was no longer the treating consultant. Due to the specific circumstances at this time, I felt I was unable to communicate my actions or convey the concerns of the family to my colleagues, particularly with the Trust’s instruction that I should have no contact with these colleagues. It is now clear to me that by permitting and engaging with contact from Ms B regarding Patient A, my behaviour had the potential to negatively impact my colleagues at RMCH, who were responsible for the continuity and coordination of Patient A’s care. Having worked tirelessly for 26 years to provide the highest level of care for my patients and support for their families, it deeply distresses me that my actions could have interfered with my colleagues ability to do the same. I can now clearly see the potential consequences of inadequate or absent communication. I am sincerely sorry that my conduct allowed these circumstances to arise.

... I am now able to recognise that my actions allowed Ms B to become dependent on me, when I was not in a position to help her professionally. My behaviour allowed professional boundaries to become blurred. They opened the door to Ms B to talk about diverse matters outside the scope of the previous doctor/patient/parent relationship. Although my intentions were only ever for the wellbeing of the patient and her family, I failed to consider Ms B’s perception in this situation. I deeply regret this, and I am very sorry for any adverse consequences caused for Ms B.

I accept full responsibility for my conduct and acknowledge that I should have handled the situation differently. Had I ended the contact with Ms B at an early stage, subsequent events could have been avoided.

I am fully committed to undertaking all necessary steps to ensure that I will not make any of these mistakes in the future. I clearly appreciate the need to make absolutely clear where professional boundaries lie and that any factors that could blur these need to be avoided or dealt with directly. I clearly appreciate the need to make absolutely clear where professional boundaries lie and that any factors that could blur these need to be avoided or dealt with directly. Due to the nature of my practice, many of my patients suffered from long-term, life threatening diseases, and I often allowed these families to have direct contact with me, which consistently provided reassurance and peace of mind for the families. For families with critically ill children to whom
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I allow direct contact, I will ensure that they understand that this direct contact is solely for clinical purposes and any conversations will be directly transferred to the patient’s clinical record at the first opportunity. Should there be any case of clinical urgency when I am not the consultant on call, they should always contact the hospital. On the rare occasions I visit families at their home, I will, wherever possible, visit with a clinical nurse specialist. I will produce a resume of the discussion after the meeting and place this in the child’s case notes as well as sending it to the family and GP. I will not develop social friendships with the families of patients for whom I have direct clinical care, or patients under the care of clinical colleagues, or any patients of any institution where the parents might perceive that the relationship is different because I am a doctor rather than a lay person.

... I do wish to continue my medical practice and I will strive to develop and maintain my professional performance and regularly reflect on my practice. The remorse I feel will stay with me for the rest of my life and I will take every necessary step to prevent similar events from recurring by ensuring that I maintain professional boundaries, lead and encourage proper inter-professional communication and cultivate a supportive work environment. This was the way I conducted my practice for 26 years as a consultant before these isolated events and how I practiced in Dublin following them. I am passionate about my work and devoted to providing the highest level of care to every child I treat. I sincerely hope that I can continue to dedicate my life to this, particularly the charitable ventures in Africa, in the future.’

7. At the Tribunal’s request, Dr Lewis gave oral evidence. He told the Tribunal ”whilst I was acting in good faith I should have perceived that I wasn’t in a position to do so.” He stated: “I now appreciate that it wasn’t the appropriate thing to do and my judgement was clouded.”

8. Dr Lewis was asked why Patient B’s circumstances were so unique, he replied: "I had a lot of patients but I have not been approached in the same way by other families, so felt inner turmoil because of the difficult time the family had been through but it was not as if I selected this family and chose to respond to them – I was selected by them.”

9. Dr Lewis stated that he attributed his actions to a heightened empathy which clouded his judgement but denied that he was pursuing a friendship with Ms B. He said “personally I don’t feel I was pursuing a relationship, which gives the connotation that I wanted to develop it into something else – I was trying to be supportive to the family at that time.”

10. When asked about the sending of a gift to Patient A, Dr Lewis said that it was a response to a gift sent from them “but I can see how it can be misconstrued and now see that it was inappropriate.” Dr Lewis also accepted that he should have
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ended the friendship with Ms B sooner and that by continuing to respond to questions from her, his actions were inappropriate.

11. When asked about his meetings with Ms B, Dr Lewis said "I do not feel that during that time I appreciated the misguidedness of my actions – I have since, and whilst it is not an excuse it was a period of time when I was going through a period of vulnerability myself and that is how I have justified to myself, that I failed to pick up what was happening – I have not had such problems before in my career – the mistake I made was not making it clear that I was not in a position to help – I mistakenly thought by acting as a listening post to her I was helping.”

12. When asked about the passing on of results, Dr Lewis said “I mistakenly thought I could smooth the relationship between the family and the treating consultants – my reason for doing what I did was to mend relationships and make things easier for the family – I appreciate the potential for confusion to arise but the specific interactions I undertook did not undermine the child’s care as I did not alter the care.”

13. Dr Lewis told the Tribunal “I have been devoted to medicine and go the extra mile but on this occasion I got it wrong as my vision was clouded by my personal circumstances – it had a big impact on me because I have been successful in treating families but on this occasion I got it wrong – my perception of matters is that the reason I strayed from normal ways was secondary to my personal situation of having false allegations made against me by the Trust. I made a mistake and accept that it was inappropriate of me to meet the mother.”

14. In response to questions from the Tribunal, Dr Lewis explained that he accessed Patient A’s biochemistry results (not medical records) at a time when he was still a part of the global team and a working member of the department and that it was very common for results to be accessed by consultants not directly looking after patients, who had cared for the patient in the past. Dr Lewis accepted that it was inappropriate of him to have conveyed results to the family in the circumstances that he did. He explained that at the time “it did not strike me as being inappropriate given the family had access to the results too.”

15. Dr Lewis accepted that him giving advice to the family when he was not the treating consultant was contrary to GMP but explained that at the time “I was merely helping the family understand the situation without in any way altering the treatment plan.”

16. Dr Lewis further accepted that him not letting Patient A’s treating consultants know of the advice he gave to the family was “not good because GMP is all about communication and making sure everyone involved in the care of a patient is aware of all advice and information given – GMP says they ought to have been made aware and there should have been a record – I recognise this has developed into a
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*situation – my feeling is still that the advice that I gave would not necessarily have been recorded in the notes in any event."

17. Dr Lewis stated that he accepted the findings of the Tribunal overall save for the perception that he was “pursuing” a relationship with Ms B. He accepted that his actions were inappropriate and that his reticence to accept at the time was due to his need to vehemently deny the sexual motivation aspect of the allegation. Dr Lewis accepted that it was inappropriate to meet Ms B and accepted that it would not have been seen in a good light by the treating consultants and would not have been in the best interests of the patient. He stated, in retrospect "my actions were inappropriate as I was not the treating consultant and I could not help this family – these were very exceptional circumstances and not something I have ever done before or will do again in the future – I don’t think the public would look at it too kindly – I accept it would not be well regarded”. Dr Lewis added that his actions will not be repeated as the circumstances were remarkably unique "I have 500% realised the problem in where I was taking myself – once the mistake has been made – can’t see it ever happening again.”

18. The Tribunal has read and taken account of the positive references and cards from patients and families. It has also noted the certificates of attendance on ‘Introduction To Professional Boundaries’ course on 11 January 2018 and the ‘Professionalism: Why it matters for Patient Safety, Quality and Risk’ course on 12 April 2018.

**Submissions On Behalf Of The GMC**

19. Mr Atherton commenced his submissions by acknowledging the high regard Dr Lewis was held in. He submitted that Dr Lewis’s clinical skills were not in issue and therefore the material adduced, relevant to these matters, was of limited value at this stage.

20. Mr Atherton submitted that Dr Lewis, a very experienced consultant, used his position to pursue a relationship with Ms B, which the Tribunal described as an inappropriate friendship. He referred the Tribunal to its determination on the facts and the observations it made regarding Dr Lewis’s evidence given at the facts stage. He submitted that the Tribunal had highlighted a number of concerns pertinent at the time of the events, including the risk of Dr Lewis giving advice regarding a patient for whom he had no clinical responsibility and the impact of that on Patient A’s care, which it found to have been inappropriate. Mr Atherton submitted that the Tribunal now has Dr Lewis’s response to its concerns which are broadly in line with his reflections made in February 2019, namely that his actions were due to his heightened empathy and clouded judgement.
21. Mr Atherton invited the Tribunal to consider whether Dr Lewis’s friendship with Ms B was a personal relationship and in that regard referred it to paragraphs 35 and 53 of GMP and supplementary guidance on professional boundaries.

22. Mr Atherton invited the Tribunal to consider the questions posed by Cox J in CHRE v NMC and Grant (2011) EWHC 927 (Admin) at paragraph 76 which he submitted provided the correct approach to the issue the Tribunal had to decide at this stage.

23. Mr Atherton invited the Tribunal to conclude that Dr Lewis must have known what the consequences would have been, had his covert advice become known to Patient A’s treating consultants. He submitted that all the factors set out by Dame Janet Smith are present in this case and that a finding of impairment is necessary.

24. Mr Atherton also submitted that when considering the matter of insight, the Tribunal should give consideration to Dr Lewis’s sense of entitlement which he had developed over a long and successful career which led him to abandon principles of GMP. He concluded his submissions by stating that it is necessary in this case to make a finding of impaired fitness to practise.

On Behalf Of Dr Lewis
25. Mr Gillespie submitted that the case that Dr Lewis now faces is considerably different to that which he faced at the outset. He submitted that his primary submission was that the conduct found in this case, albeit inappropriate, was not deplorable and did not reach the threshold to justify making a finding of misconduct.

26. Mr Gillespie submitted that if the Tribunal were against him on that submission, he invited it to conclude that Dr Lewis is not currently impaired given Dr Lewis’s insight, remediation and the wholly unique circumstances of this case, which are most unlikely to reoccur.

27. Mr Gillespie submitted that not every falling short of the standard amounts to misconduct and that the starting point must be the factual findings. He invited the Tribunal to consider, if the proven facts had gone before the Case Examiner, whether Dr Lewis’s case would have proceeded to a hearing.

28. Mr Gillespie reminded the Tribunal that the initial contact was made by Patient A’s mother and that Dr Lewis’s motivation in responding, although misguided, was well intentioned, namely to help the family of the child who he had previously treated. He submitted that Dr Lewis did not seek to challenge any part of the Tribunal’s findings; he accepts that he did wrong; the inappropriate friendship with Ms B; and that he should not have advised Ms B on the dosages of Patient A’s medication, albeit the Tribunal accepted that the advice he did give was in line with that given by Patient A’s treating consultants.
29. As to misconduct, Mr Gillespie referred the Tribunal to relevant caselaw, including Roylance v GMC [2001] 1 AC 311 and Nandi v GMC [2004] EWHC 2317 (Admin). He submitted that as the sexual elements of the allegation were no longer relevant, the Tribunal was left with is a doctor of unblemished conduct who made a mistake and behaved unwisely; but because he cared for the patient. He submitted that Dr Lewis’s actions do not cross the threshold for a finding of misconduct.

30. Mr Gillespie invited the Tribunal to take account of the following factors, namely that Dr Lewis:
   - did not initiate the contact with Ms B;
   - was aware of Patient A, since he was her former treating consultant;
   - had a motivation only to help;
   - did not go beyond what the treating consultants were proposing;
   - did not undermine the advice of the treating consultants.

31. In relation to impairment, Mr Gillespie invited the Tribunal to consider the factors set out by Dame Janet Smith and her Fifth Shipman Report and to paragraph 64 of Cohen v GMC [2008] EWHC 581 (Admin). He submitted that in the instant case there is one patient, one course of conduct and wholly unusual circumstances which are highly unlikely to reoccur. He invited the Tribunal to consider the context of the case and in this regard referred it to paragraph 22 of Cheatle v GMC [2009] EWHC 645 (Admin), which he submitted was pertinent to the case in question. He also referred to the case of CHRE v NMC and Paula Grant [2011] EWHC 297 (Admin).

32. Mr Gillespie then drew the Tribunal’s attention to parts of Dr Lewis’s reflective statements and submitted that Dr Lewis had a full appreciation of what went wrong and in view of this, his actions would not be repeated.

33. Mr Gillespie submitted that a well informed member of the public, knowing the precise nature of the allegation would not feel it necessary for Dr Lewis’s conduct to be marked with a finding of impairment. He further repeated the unique circumstances of this case and the fact that there had not been a repetition of the conduct since the allegation. Mr Gillespie finally submitted that, contrary to the GMC submissions, the material adduced attesting to his skills and experience, was highly relevant since Dr Lewis has had a long and successful career and the evidence demonstrates his significant insight and remediation undertaken to date.

The Relevant Legal Principles

34. The Tribunal and parties accepted the advice of the Legally Qualified Chair. The Tribunal reminded itself that, at this stage of the proceedings, there is no burden or standard of proof and the decision on impairment is a matter for the Tribunal’s judgement alone.
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35. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, which had to be serious. If so, whether the finding of serious misconduct amounted to current impairment.

36. The Tribunal reminded itself that it must determine whether Dr Lewis’s fitness to practise is impaired today, taking into account Dr Lewis’s conduct at the time of the events and any relevant factors since, such as whether the matters are remediable, have been remedied and any likelihood of repetition.

37. In considering whether Dr Lewis’s fitness to practise is impaired the Tribunal must look forward not back. However, in order to form a view as to his fitness to practise today, the Tribunal should take into account the way he acted or failed to act in the past and how he is likely to act in the future.

The Tribunal’s Determination on Impairment

Misconduct

38. The Tribunal first considered whether the facts as found proved amounted to serious misconduct. Misconduct can be found in circumstances where there have been serious departures from expected standards of conduct and behaviour, which can be identified by reference to GMP 2013 (applicable at the time of the events).

39. The Tribunal limited its enquiry as to the facts found proved, namely:

- gaining access to blood tests of a former patient;
- conveying the test results to the mother of the patient;
- meeting with the mother on more than one occasion to discuss treatment;
- advising on dosages of medication of Frusemide;
- sending a gift to his former patient at her home address; and
- failing to disclose the advice he had given to the mother to Patient A’s treating consultants.

40. In its determination on the facts, the Tribunal found that during a three month period, Dr Lewis provided covert advice and assistance in relation to the decisions that were being made by Patient A’s treating consultants. It also found that there was a real risk that Dr Lewis’ advice or assistance could undermine and directly impact on the care being provided to her, in particular as he knew he had no clinical responsibility for her and that he had previously been in dispute with the Trust.

41. The Tribunal considered the context, namely that following the initial contact from Patient A’s mother, there followed numerous contacts between Dr Lewis and Ms B. This included meeting for coffee outside the hospital grounds on a number of
occasions and meeting with the family at their home. The Tribunal finds that Dr Lewis allowed the contact to develop for a prolonged period.

42. Dr Lewis also undertook a number of actions on behalf of Ms B, including accessing and conveying blood tests and giving advice as to Patient A’s treatment. In his reflective statement Dr Lewis said that by giving the advice, he was attempting to reassure the parents. However, during this time, Dr Lewis knew he was not the treating consultant owing to a prior dispute with the Trust, which ultimately resulted in his resignation. Dr Lewis knew that the treating consultant would not have taken kindly to him giving the parents advice, even if it was consistent with theirs. In addition, Dr Lewis had no clinical responsibility for Patient A as he had resigned from the Trust. To compound all of this, no attempt was made by Dr Lewis to communicate the advice he had given to Ms B to Patient A’s treating team which would have allowed them to make a record of those discussions on Patient A’s clinical notes.

43. The Tribunal notes, with concern, that at no point during the three-month period did Dr Lewis stop to think that his actions may have been inappropriate, despite being a senior and experienced Consultant and those actions being contrary to GMP.

44. In reaching its decision on misconduct, the Tribunal had regard to paragraphs 20, 21, 35 and 65 of the GMC’s guidance, Good Medical Practice (2013), which state:

‘20. You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.

21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when.

35. You must work collaboratively with colleagues, respecting their skills and contributions.

65. You must make sure that your conduct justifies your patients’ trust in you and the public’s trust in the profession.’
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45. The Tribunal considered that Dr Lewis’s actions engaged and contravened the above paragraphs of GMP. It was of the view that an informed member of the public, knowing all of the facts, would not expect a doctor to behave in a way which would have caused confusion in the minds of the parents and may have put a patient at risk, albeit accepting that Dr Lewis’s motivation was to help.

46. The Tribunal was satisfied that Dr Lewis’s failings were serious and they clearly breached the principles set out in GMP. The Tribunal further considered that it was necessary to view Dr Lewis’s actions as a whole, with each action being part of a course of conduct. The trigger for Dr Lewis’s actions was his willingness to entertain Ms B’s requests to meet with her over a prolonged period of time. This provided a platform for Ms B to seek advice, as well as making requests for blood tests, which were acceded to by Dr Lewis. Had Dr Lewis declined Ms B’s requests to meet with her, none of the inappropriate actions taken by him would have come to pass.

47. The Tribunal therefore considered that the combination of Dr Lewis’s inappropriate actions amounted to misconduct.

48. In any event, the Tribunal considered that the fact that Dr Lewis met with Ms B over three months when he was not Patient A’s treating consultant to discuss her care, in very delicate and difficult circumstances, involving a past dispute with his employers, was sufficiently serious to amount to misconduct. This, in itself, was wholly inappropriate given the possibility of causing confusion to Ms B, given her vulnerability owing to Patient A’s significant ill health.

Impairment

49. The Tribunal having found misconduct, went on to consider whether, as a result of that misconduct, Dr Lewis’s fitness to practise is currently impaired.

50. The Tribunal considered the factors as set out by Dame Janet Smith in her Fifth Shipman Report and cited by Cox J in CHRE v NMC and Grant (2011) EWHC 927 (Admin) at paragraph 76, namely:

'Do our findings of fact in respect of the doctor's misconduct...show that his/her fitness to practise is impaired in the sense that s/he:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or
51. The Tribunal is satisfied that limbs a and b above were met in this case insofar as they related to Dr Lewis’s past conduct. It found that Dr Lewis in giving advice to the mother of Patient A could have put her at risk of harm, although it accepts that there was no direct harm caused in this case. It further considered that Dr Lewis’s actions did bring profession into disrepute given the inappropriate relationship with Ms B over a prolonged period. Whilst there had been breaches of GMP, the Tribunal did not consider that the facts found proved went so far as to amount to a past breach of one of the fundamental tenets of the medical profession.

52. The Tribunal next considered these issues in relation to Dr Lewis’s future conduct, having regard to Dr Lewis’s insight, remediation and the risk of repetition.

53. As to insight, Dr Lewis accepted the Tribunal’s findings, has developed significant insight into his actions and has accepted the implications of his actions. This is apparent from his reflective statements and from his oral evidence.

54. Having said that, the Tribunal noted Dr Lewis’s insight pertaining to the initiation of the relationship with Ms B. Dr Lewis took issue with the use of the word “pursuing” in the context of pursuing a relationship with Ms B. He said he did not consider this to be accurate in his case. The Tribunal gained the impression that he attempted to justify his actions by stating “I didn’t contact her, she contacted me” and “I was chosen by them”. Whilst the Tribunal notes Dr Lewis’s reflections that he should not have met with Ms B, it considered that this is an area where Dr Lewis may benefit from further developing his insight.

55. As to remediation, the Tribunal noted that Dr Lewis attended relevant courses included a professional boundary course. He produced reflective statements detailing his state of mind at the time of the events which set out future steps to safeguard and prevent a recurrence. It is clear that Dr Lewis has understood the issues of concern and has an appreciation of the inappropriateness of the relationship with Ms B. The Tribunal also noted that Dr Lewis has maintained his clinical skills and he has not allowed these proceedings or his past dispute with his employers to prevent him from continuing his learning. He has actively engaged with his profession so that he remains a highly skilled practitioner, which the Tribunal considered to be an important element of remediation.

56. The Tribunal has considered Dr Lewis’s reflective statements. It finds these were well structured and covered all the important areas, including his evaluations and future steps. The Tribunal is of the view that Dr Lewis demonstrated well developed insight of the impact of his actions on others. However, it noted that in
his evaluation of his actions, Dr Lewis appeared to place some responsibility with others, for example when stating that it was Ms B who initiated contact and that he could not communicate with the treating consultants as the Trust had forbidden this. As above, the Tribunal considers these are matters into which Dr Lewis would benefit from gaining further insight.

57. As to the risk of repetition, the Tribunal considers this to be low, given the significant level of insight developed by him, his remediation and the clear impact these proceedings have had on him. That impact has been felt by Dr Lewis not only by the stress of these proceedings but that associated with his dispute with the Trust, which ultimately led to his resignation. That has been compounded by his further resignation from his post in Dublin following unfavourable press reports.

58. The Tribunal was satisfied that Dr Lewis’s misconduct is remediable and there is good evidence to demonstrate that Dr Lewis has taken steps to remediate his conduct. He has attended two CPD courses, specifically addressing the misconduct that the Tribunal has found, in the areas of professional boundaries. During oral evidence and in his structured reflective document, he also demonstrated significant insight, reflection and remorse. The Tribunal considered that these factors meant that the risk of repetition was low.

59. It is clear to the Tribunal that Dr Lewis is a highly-respected, experienced and valued doctor with high standards of probity and integrity. In his evidence he openly acknowledged where he fell into error and has fully accepted the Tribunal’s findings. Although his actions were misguided and unwise, they can be regarded as a regrettable anomaly in an otherwise distinguished and unblemished career.

60. In all the circumstances, the Tribunal considered that a finding of impairment was not necessary in Dr Lewis’s case to protect and promote the health, safety and wellbeing of the public.

61. The Tribunal next considered the public interest in this case, specifically the need to maintain public confidence in the medical profession and maintain proper professional standards and conduct for members of the profession. Whilst the Tribunal recognised that a finding of misconduct has been made against Dr Lewis, having regard to the particular circumstances of Dr Lewis’s case, namely his genuine insight, remediation and low risk of repetition, the Tribunal was satisfied that the public interest would not be undermined if a finding of impairment were not made. In this case the public interest is best served by allowing a highly experienced and distinguished doctor to continue to practise.

62. Having considered all the circumstances, the Tribunal has determined that Dr Lewis’s fitness to practise is not currently impaired by reason of misconduct.
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Determination on Warning - 19/09/2019

1. As the Tribunal determined that Dr Lewis’s fitness to practise was not impaired it considered whether in accordance with Section 35D(3) of the Medical Act 1983 and under Rule 17(2)(m) of the Rules, a warning was required.

Submissions

On Behalf Of The GMC

2. Mr Atherton submitted that the GMC sought a warning in this case. He directed the Tribunal’s attention to the document ‘General Medical Council Guidance on Warnings’ (February 2018 edition) (‘the Guidance’) and in particular to paragraphs 11, 16, 19, 33.

3. Mr Atherton submitted that the Tribunal in its determination on impairment has identified significant departures from GMP and that the matter of whether a warning was necessary is a matter for the Tribunal’s judgement.

Submissions on behalf of Dr Lewis

4. Mr Gillespie submitted that a warning would not be necessary nor appropriate in Dr Lewis’s case. He directed the Tribunal’s attention to its determination on impairment where it concluded that because of Dr Lewis’s insight, the risk of him repeating his behaviour is low.

5. Mr Gillespie submitted that all the factors in relation to mitigation and insight at paragraph 33 of the Warnings Guidance are present in Dr Lewis’s case. He submitted that it is quite clear Dr Lewis has accepted that his conduct was inappropriate and that the only dispute is the question of “pursuing”. Mr Gillespie reminded the Tribunal that it accepted Dr Lewis was not pursuing Ms B but he had allowed contact to continue and accepts that he should not have done so.

6. Mr Gillespie invited the Tribunal to take into account the following factors:

   • Dr Lewis has genuinely expressed his regret and apology in writing and in his oral evidence;
   • This was one episode in the course of a 30-year career – although it took place over a three month period it can be described as very isolated;
   • There has been no repetition of the misconduct;
   • These were a very unique set of circumstances;
   • Dr Lewis has attended appropriate courses and reflected on them;
   • Relevant testimonials have been adduced;
   • Dr Lewis’s previous good history;
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- Dr Lewis has pioneered and developed innovations in his specialist area of nephrology and made “enormous contributions” in this field;
- Dr Lewis has undertaken research projects and his CV details the long list of publications that he has produced;
- Dr Lewis wrote the initial database for the UK wide paediatric renal registry which shows an exceptional contribution to his field of medicine and has been the recipient of various awards as a result of his work.

7. Mr Gillespie submitted that Dr Lewis is at the top of his profession in his specialist field and has made a “gigantic” contribution. He referred the Tribunal to the powerful mitigation that is backed up by the references, cards and the video evidence.

8. Mr Gillespie submitted that this entire process has taken a toll on Dr Lewis and the consequences of these proceedings have been severe; he had to resign from his position in Ireland as a result of the adverse publicity surrounding this hearing.

9. Mr Gillespie submitted that the Tribunal has already marked the seriousness with which it views Dr Lewis’s action by the finding of misconduct and that no other action is required.

The Tribunal’s Approach

10. The decision whether or not to issue a warning is a matter for the Tribunal alone to determine, exercising its own professional judgement. In making its decision, the Tribunal had regard to the Guidance.

11. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective. In that regard, it bore in mind that its power to issue a warning is an important feature of its role of protecting the public, which includes the need to:

   a. Protect, promote and maintain the health, safety and well-being of the public,
   b. Promote and maintain public confidence in the medical profession, and
   c. Promote and maintain proper professional standards and conduct for members of that profession.

12. In deciding whether or not to issue a warning, the Tribunal applied the principle of proportionality, and weighed the interests of the public against Dr Lewis’s interests.
The Tribunal’s Determination on a Warning

13. The Tribunal noted paragraph 33 of the Guidance, which states:

‘However, if the decision makers are satisfied that the doctor’s fitness to practise is not impaired or that the realistic prospect test is not met, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate. These might include:

- the level of insight into the failings.
  a. A genuine expression of regret/apology.
  b. Previous good history.
  c. Whether the incident was isolated or whether there has been any repetition.
  d. Any indicators as to the likelihood of the concerns being repeated.
  e. Any rehabilitative/corrective steps taken.
  f. Relevant and appropriate references and testimonials.’

14. Taking the above into account, the Tribunal had regard to the following mitigating factors in Dr Lewis’s case:

- considerable insight;
- genuine expressions of remorse in his written and oral testimony;
- extensive reflective material;
- testimonials from colleagues and patients;
- no evidence of repetition of his actions; and
- a low risk of repetition in the future.

15. The Tribunal also took account of the fact that Dr Lewis’s misconduct was in respect of a single patient and occurred over a three month period in 2016, over three years ago, in the context of a long and distinguished career.

16. The Tribunal reminded itself that its decision that Dr Lewis’s fitness to practise was not currently impaired was influenced to a considerable degree by the existence of the above mitigating factors, his insight and remediation since the index events.

17. The Tribunal has found that there were departures from GMP and views those as significant. However, it recognised that Dr Lewis’s desire, albeit misguided, was
to assist the family. It also gave considerable weight to the mitigating factors in this case.

18. The Tribunal has already determined that Dr Lewis has insight into his behaviour and is very unlikely to repeat it. It was apparent to the Tribunal that he understood what he needed to change and that he has taken the requisite steps to achieve that change. In its determination on impairment, the Tribunal has found that all six of the mitigating factors in paragraph 33 of the Guidance, set out above, have been satisfied.

19. The Tribunal recognised the purpose of marking a doctor’s misconduct with a warning. However, in the circumstances of this case, it was satisfied a finding of misconduct at a public hearing was sufficient to signal the seriousness of the misconduct. The Tribunal considered it unnecessary to additionally underscore the misconduct finding with a warning on public interest grounds alone.

20. The Tribunal has therefore determined that in all the circumstances, issuing a warning would not be proportionate or appropriate.

21. That concludes the case.

Confirmed
Date 19 September 2019

Mr Hassan Khan, Chair
ANNEX A – 25/02/2019

Rule 17(2)(g) Application

1. At the conclusion of the GMC’s case, Mr Gillespie, on behalf of Dr Lewis, made a submission of ‘no case to answer’ under Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended (‘the Rules’), which states:

‘the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld.’

Submissions on behalf of Dr Lewis

2. Mr Gillespie submitted that the test to be applied by a Medical Practitioners Tribunal in determining whether to accede to a submission of no case to answer is that set out, suitably modified, for regulatory proceedings, by Lord Lane LCJ in R v Galbraith [1981] 1 WLR 1039 at 1042:

‘(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty – the judge will stop the case.

(2) The difficult arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.

(a) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case.

(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witnesses reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.’

3. Mr Gillespie reminded the Tribunal that all the matters set out at paragraph 2 a – i are said by the GMC at paragraph 3 to be sexually motivated. He referred the
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Tribunal to the case of Basson v GMC [2018] EWHC 505 (Admin) where Mostyn J stated at paragraph 14:

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

4. He also referred the Tribunal to paragraph 17 of the judgement, where Mostyn J observed that a person’s state of mind can only be proved by inference or deduction from the surrounding evidence.

5. Mr Gillespie then referred to the case of Sait v GMC [2018] EWHC 3160 (Admin) where the same judge stated at paragraph 38 that where sexual motivation is alleged it should be made clear which of the two types of sexual motivation identified in Basson is being alleged.

6. Mr Gillespie submitted that applying the principles set out in Galbraith Dr Lewis has no case to answer in respect of the following parts of the allegation, namely:
   - Paragraph 2 e (i);
   - Paragraph 2 f (i);
   - Paragraph 2 g (iii);
   - Paragraph 2 (h); and
   - Paragraph 3 insofar as it relates to 2 a, b, c, d, e (i) and (ii), f (i) and (ii) and i.

7. Mr Gillespie provided a summary of the evidence in relation to the paragraphs that form this application.

8. In relation to 2 e (i) – Mr Gillespie submitted that Ms B was the only witness to this conversation. Her evidence was that Dr Lewis’ comments in relation to the creation of an arteriovenous fistula were not said in a manner critical of the treating consultants but rather as an example of the different potential ways of treating and managing Patient A’s condition. He reminded the Tribunal of the evidence of Patient A’s complex problem where there were different medical opinions and re-iterated Ms B’s acceptance that what Dr Lewis said was not critical.

9. In relation to 2 f (i) – Mr Gillespie submitted that it is unclear on the evidence whether Patient A was on a fixed or variable dose of Frusemide and referred the Tribunal to C2 page 130, the notes of Ms B’s interview for the Trust Investigation. He submitted that there is a clear indication from Ms B that it was a variable dosage.

10. Mr Gillespie referred to the evidence of Dr H, GMC expert witness and his opinion expressed in his report: 'If the dose of frusemide had not been a variable dose range and Dr Lewis had given advice to Patient A’s mother on changing the dose, after he was no longer Patient A’s treating consultant, this would amount to
being below but not seriously below the expected standard for a reasonably
cOMPETENT CONSULTANT PaeDIATRIC NEphrologist. It would not be seriously below as Dr
Lewis is an experienced Consultant Nephrologist and would be giving that advice
based on his knowledge and experience.’

11. Mr Gillespie submitted that there is no other evidence as to whether
Frusemide was being administered in a fixed or variable dose.

12. In relation to 2 q (iii) – Mr Gillespie submitted that there was a real paucity of
evidence in relation to this sub-paragraph. He reminded the Tribunal of the evidence
of Mr C, which was that he had seen texts/WhatsApp messages, which made it clear
to him that Ms B and Dr Lewis had been in a sexual relationship. He submitted that
Mr C was vague as to the detail of the messages and that where he did give some
detail, for example referring to messages where Dr Lewis and/or Ms B stated they
could not wait to be in each other’s arms again, this was specifically denied by Ms B.

13. Mr Gillespie submitted that Ms B was also vague as to the contents of the
messages. She said that the messages contained innuendo and descriptions of what
Dr Lewis and she would like to do to one another but she gave no further detail. He
submitted that she was given every opportunity by both Counsel and by the Tribunal
in its questions to expand on her evidence but she did not do so. Mr Gillespie further
submitted that none of the messages are available to be seen by the Tribunal.

14. In relation to 2 (h) – Mr Gillespie submitted that Ms B is the only witness to
give evidence as to what happened. In evidence she could not say what Dr Lewis
was doing during the Facetime call. He referred to the defence note of her evidence
as follows:

"Q: You say you could see hand movements under the duvet which gave you
the impression he was masturbating.
A: Possibly yes
Q: You don’t know?
A: I couldn’t categorically say, no...
... Q: He gave you the impression he was masturbating is that what you
thought at the time?
A: Its what it looked like so I terminated the call."

15. Mr Gillespie referred the Tribunal to the notes of the meeting with Dr F on 6
October 2016 and submitted that there is no record of masturbation having been
mentioned. He reminded the Tribunal that Ms B stated either that she had told Dr F
that Dr Lewis had been masturbating but that he had failed to record this or that she
had not said it at all through reticence.

16. In relation to 3 insofar as it relates to 2 a, b, c, d, e (i) and (ii), f (i) and (ii)
and i – Mr Gillespie submitted that it is not clear what evidence there is to support
the contention that Dr Lewis’ acts at paragraphs 2 a, b, c, d, e, f and i were sexually motivated in either of the senses of the phrase as explained by Mostyn J.

17. In summary, Mr Gillespie submitted that:

- The evidence in relation to 2e(i) and 2f(i) fails limb one of the Galbraith test;
- The evidence in relation to 2g(iii) fails limb one and two of the Galbraith test – he submitted that this is a very serious allegation but there is no evidence for the Tribunal to test or consider. He accepted that there is evidence in relation to 2g(i) and 2g(ii) but submitted that 2g(iii) is very different and the Tribunal has not been presented with the actual messages and there was no evidence given by Mr C or Ms B to specify the sexualised language;
- The evidence in relation to 2 (h) fails on limb 1 and alternatively on limb 2 of the Galbraith test. He submitted that there is no doubt that the evidence is insufficient to establish at this stage of the proceedings that Dr Lewis was masturbating. He added that it would be wholly unfair if an adverse factual finding could be made against Dr Lewis on the basis that whatever he was doing may have looked like masturbating even if he was not and had no intention of giving that impression; and
- The evidence in relation to 3 fails on limb 1 of the Galbraith test. He submitted that the GMC’s real case is that Dr Lewis’ actions at 2 a – f and i were as a result of some vendetta against his former colleagues. He argued that there is absolutely no direct evidence and no proper inference to be drawn that Dr Lewis performed these actions either for his own sexual gratification or in pursuit of a future sexual relationship with Ms B.

Submissions on behalf of the GMC

18. Mr Atherton, on behalf of the GMC, submitted that the test for the Tribunal was whether it could find the facts proved, and not whether it should. He stated that any such finding was a matter for the Tribunal. He submitted that on any view of the evidence Dr Lewis’ judgement should be considered as all of the events that form the allegation occurred against a background of his restrictions imposed on Dr Lewis’ practice by the Trust.

19. Mr Atherton submitted that Dr Lewis had no clinical responsibility for Patient A after December 2015 and he knew nothing of her personal circumstances until the messaging began in June 2016. He submitted that it was Dr Lewis who initiated contact with Ms B by sending her a Whatsapp message after seeing her in the corridor of the hospital in June. Mr Atherton submitted that the purpose of this was to initiate a personal contact with Ms B and it happened whilst his practice was restricted by the Trust.
20. Mr Atherton submitted that the inference can be made that it is likely that Dr Lewis had some awareness of ongoing concerns of the family in relation to the care of Patient A and that he initiated the contact with Ms B in order to achieve his goal of a future sexual relationship with her. He submitted that the GMC “do put this as a grooming case” with the sending of up to 1000 sexualised messages and all of the contact which took place outside of the professional setting. He argued that the Tribunal should stand back and ask “why on earth would Dr Lewis be sending Whatsapp messages and why suggest she installs the Telegram app?” Mr Atherton accepted that although there is no evidence of the texts, he submitted that there are inferences that can be made. He reminded the Tribunal that Ms B confessed to a cyber affair and said they exchanged messages of what they would do to each other – she said they were sexualised and the Tribunal can infer that the purpose in sending them was to establish a sexual relationship. Mr Atherton submitted that Dr Lewis showed a complete lack of judgement and disregard to the consequences when he infiltrated Ms B’s life and tore apart her family.

21. Mr Atherton then responded to each of the paragraphs that formed the submission of no case to answer.

22. In relation to paragraph 2 e (i) – Mr Atherton submitted that one of the aspects of the evidence is that when Dr Lewis was visiting Ms B at her home and encouraging her to make a complaint, his motivation was possibly twofold – “perhaps part was to get back at his colleagues but why has he taken a particular interest, in this particular woman?” Mr Atherton argued that this is how grooming works and suggested that Dr Lewis exploited her vulnerability and her worry about the deterioration in her child’s health and her concern about the sufficiency of the consultant care.

23. Mr Atherton referred the Tribunal to Dr Lewis’ response to the allegation as set out in his letter to the Trust dated 23 February 2017: ‘... Ms B kept coming back to me for reassurance and advice. Regrettably now in retrospect, my sympathy for her plight meant I allowed her to do this. She would describe to me the clinical situation and I would try to help her understand it or help advise her about the questions she needed to ask of the consultants to get the answers she needed. My personal, but certainly not expressed, feeling that Patient A’s care was significantly suboptimal spurred me on to try to help her battle her way through this and regain confidence in the medical team.’

24. Mr Atherton submitted that Dr Lewis was a consultant at the top of his game “who clearly lost his way”. He reminded the Tribunal of Ms B’s oral evidence “Dr Lewis wanted me to complain about the other doctors” and that “he offered to edit my complaint”. Mr Atherton submitted that Dr Lewis was using Ms B for his own purposes, these being “anger, retribution and sexual motivation”.

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25. In relation to paragraph 2f(ii) – Mr Atherton submitted “what better way in cementing the relationship then being the online consultant responding to her questions of dosage of Tac”. He submitted that this allegation is not a reference to fixed or variable doses – “its about one of the ways he used to further the relationship”.

26. In relation to paragraph 2g(iii) – Mr Atherton submitted that Mr Gillespie’s prominent point is that there are no sexualised messages that have been presented to the Tribunal. He referred the Tribunal to the emails between the parents and to their oral evidence and submitted that the Tribunal can form a view whether Ms B wanted to expose her life to all. He added that it was clear when she said she “didn’t want to go there” that she found it excruciatingly embarrassing. He accepted that there are inconsistencies in her evidence and accepted that there are negative traits to Mr C’s personality but that did not mean that they were lying in their evidence.

27. In relation to paragraph 2(h) – Mr Atherton posed the question “Why is Dr Lewis facetimeing in bed, topless and drinking wine?” He submitted that if Ms B is being truthful then Dr Lewis was doing something which may not have been overt but it was something she understood and therefore terminated the call.

28. Mr Atherton concluded his submissions by stating that applying the Galbraith test, there is evidence to proceed further on all of the paragraphs of the allegation.

The Tribunal’s Approach

29. The Tribunal reminded itself of the test set out in \textit{R v Galbraith} referred to by Mr Gillespie at the outset of his submissions. It noted that this is a case from the criminal jurisdiction and that whilst the terminology used refers to that jurisdiction the principles to be applied are relevant in its consideration of this application.

30. The Tribunal also took account of the case of Basson v GMC and Sait v GMC referred to by Mr Gillespie above.

The Tribunal’s Decision

31. The Tribunal considered the oral submissions of both parties, and Mr Gillespie’s written submissions, and reminded itself of the need to express clear reasons for any decision made that enables the parties to understand any such decision.

32. The Tribunal has borne in mind that its role at this stage of proceedings is not to make findings of fact but to determine whether the evidence heard is such that the Tribunal, properly directed, could find an alleged fact proved on the balance of probabilities.
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In relation to paragraph 2 e (i) - Acceded

33. The Tribunal has been presented with the following evidence:

- Ms B’s witness statement – C1 page 18 paragraph 20: ‘However, Dr Lewis not only gave advice about Patient A’s treatment, but also undermined the other doctors at RMCH who were treating Patient A in the renal department. Dr Lewis phrased his messages along the lines that ‘if I were treating Patient A, I would do this’. Having reflected on the way these messages were put, I feel as though Dr Lewis was angry with RMCH and bitter about the internal investigation and was channelling this anger about this through Patient A, by criticising how the consultants at RMCH were treating Patient A.’

and Page 16 paragraph 15: ‘For example, Dr Lewis told me that he would have had a fistula created before Patient A’s transplant, which would delayed her transplant’.

- Dr Lewis’ letter at C2 page 164 – ‘My plan after this was to first stabilise her on peritoneal dialysis, second arrange for her to have bilateral native nephrectomies (as she still had a urine output and was clinically nephrotic as a result), third to have an arteriovenous fistula formed and allow this to mature. ... I felt that with her eczema and with the added risk of infection because of immunosuppression, having an arterio-venous fistula would be a better option than having a medium term (at least) central venous catheter.’

- Ms B’s oral evidence – she confirmed that he did express this opinion – she accepted Dr Lewis was not making criticisms and that it was what he would have done had he been the treating consultant. She said it was his thinking that if everything else failed Patient A would have still had the fistula and that it was not necessarily a criticism of the other consultants.

- Medical Records – in C3 page 1570 – show that a fistula was fitted on 27 July 2016.

34. The Tribunal finds having considered the above evidence that there is no evidence to establish this sub-paragraph for two reasons:

- Ms B’s oral evidence was that she did not construe Dr Lewis’ advice as being in any way critical of the treating consultants; and
- Dr Lewis’ view expressed in his letter dated 23 February 2017 was just one view amongst a range of alternative views.

35. The combination of this evidence is that Dr Lewis did not express an unfavourable opinion as set out in 2 e (i).
36. Accordingly, the Tribunal accedes to the application and paragraph 2 e (i) has been deleted from the allegation.

In relation to paragraph 2 f (i) – Rejected

37. The Tribunal has been presented with the following evidence:

- Ms B’s statement – C1 page 20 paragraph 31: ‘When we discussed Patient A’s treatment, we would discuss the failure of the transplant and the dosages of her medication, Tacrolimus and Frusemide. Patient A was sensitive to Tacrolimus, as it would affect her blood pressure. If Patient A was on a dosage of 6mgs of Tacrolimus, for example, and her blood pressure level was high, I would ask Dr Lewis what to do. Dr Lewis would then suggest adjusting Patient A’s dosage of Tacrolimus, to 4mls for example.’

- Ms B’s oral evidence— “Patient A would message her weight and b/p to Dr L and he would tell her how much Frusemide to take.”

- Trust Investigation meeting – C2 page 130 – ‘Her weight was up so she would text and say her weight is X and BP is Y a bit like having an online consultant. He would say “today take 60mg of frusemide” I was happy with that.’

38. The Tribunal finds that irrespective of whether Frusemide was prescribed as a fixed or variable dose, there is sufficient evidence that Dr Lewis may have given advice on dosage. Given this, the Tribunal has concluded that there is a case to answer as to whether Dr Lewis used his professional position to pursue an inappropriate relationship with Ms B, in circumstances where he was no longer the treating consultant. It finds that this does not meet limb 1 or 2 of Galbraith. Accordingly, the application in relation to 2 f (i) is rejected.

In relation to paragraph 2 g (iii) – Rejected

39. The Tribunal has been presented with the following evidence:

- Ms B in her statement: ‘Over the next few months our messages progressed to the point where we were exchanging sexual messages, or “sexting”, on a daily basis. I cannot recollect exactly what was said in these types of messages. I was flattered by this attention.’

- Ms B’s oral evidence – she said “I don’t really want to go into that” – when pressed she elaborated – "just a lot of sexual innuendos – if we ever got together what would happen – what we would do”– She said she could not recall if any said “I can’t wait to hold you in my arms” but that there were over a thousand messages sent. Ms B said in evidence most of the messages were deleted on a daily basis and that she deleted her Whatsapp account. When it was suggested that there were no sexual messages, she replied “I
know what happened – Dr Lewis knows what happened my conscience is clear.” She described having a "cyber affair” by which she meant it was talk of what would happen in "graphic detail”.

- In re-examination Ms B was asked why she had deleted the messages, to which she responded “Because of the nature of the messages”. She also gave evidence as to how Dr Lewis told her to download the telegram ‘app’ as it was more secure and encrypted to exchange messages.

- At the Trust meeting – C2 page 131- when Ms B was asked ‘How many messages would you say there may have been?’ She replied ‘Thousands over a two to three month period’

- Mr C’s statement – C1 page 34 paragraph 36: ‘One text was from Dr Lewis to Ms B which started with ‘My Darling’. Another text, from Dr said ‘I miss you so much and can’t wait to hold you, touch you again’ or words to that effect.’ Mr C confirmed this in his oral evidence.

40. The Tribunal noted that there is no evidence of the actual messages themselves as they are no longer available. The Tribunal has noted the evidence of Ms B of the number of messages sent, her acceptance of there being a cyber affair and the messages being sexualised and graphic in detail. She did not however elaborate as to what the detail was.

41. As there is some evidence, the Tribunal finds that limb 1 of the Galbraith test is not met. As to limb 2, in light of the evidence, it considers there is sufficient evidence that is not of such a tenuous character that a Tribunal, properly directed, could find the facts proved. Accordingly, the application in relation to paragraph 2 g (iii) is rejected.

In relation to paragraph 2 (h) - Acceded

42. The Tribunal has been presented with the following evidence:

- Ms B’s statement ‘In September 2016 I had a facetime call with Dr Lewis in the evening, at around 10 p.m. I was in a bedroom at my mother’s home, sitting on the bed with Patient A next to me. On this facetime call I could see that Dr Lewis was lying in a bed with a shirt off, drinking wine. Dr Lewis would have been able to see that Patient A was next to me. During this call, I could see that Dr Lewis was making hand movements underneath the duvet around his groin area. Although I could not see exactly what Dr Lewis was doing as his hands were beneath the duvet, the fact that I could see movement beneath the duvet, he had no shirt on and was drinking wine, gave me the impression that Dr Lewis was masturbating. I terminated the facetime call. This call lasted for about four minutes in total. Patient A was 14
years old at the time. I do not think that Patient A picked up on what Dr Lewis was doing, but I think that was only because Patient A was naive.’

• In his written submission of ‘No Case To Answer’ Mr Gillespie makes reference to Ms B’s oral evidence contained therein -
"Q: You say you could see hand movements under the duvet which gave you the impression he was masturbating.
A: Possibly yes
Q: You don’t know?
A: I couldn’t categorically say, no...
... Q: He gave you the impression he was masturbating is that what you thought at the time?
A: Its what it looked like so I terminated the call.”

• Trust Investigation Meeting – 6 October 2016- Ms B said: 'He was lying on the bed with his t-shirt off, drinking wine. I felt uneasy. He knew that Patient A was next to me but it wasn’t appropriate. I ended contact. It wasn’t appropriate. He was in Dublin and it was about 9 or 10pm at night.’

• Ms B’s oral evidence – she was asked why there was no mention of the masturbating at the Trust meeting. She replied "it was mentioned“ and suggested that Mr F had left it out. When asked why she did not ask for this to be included when asked to review the notes of the meeting, she said "I thought I had said it just wanted it out of the way really wasn’t interested not my priority.” She maintained that the facetime call took place "It did take place – I can describe the room – the bed was against white wall and two bedside cabinets ... there was a glass of wine on the table”. She was unable to say with certainty that he was masturbating and could not elaborate the hand movement. She stated that she was a “very private person and don’t like discussing private matters.”

• Mr F’s oral evidence: "had she said Dr Lewis was lying in bed masturbating then I would have noted that as it would have been a startling and shocking – it would not be something I would forget to include in the notes of the meeting.”

• Mr C’s evidence: "My middle daughter told me of the facetime call when Dr L was lying naked in bed and masturbating – and of wife ending the call – so I called my wife and asked her and she confirmed it – and it was only then that she told me that she ended any communication between Patient A and Dr L.”

43. The Tribunal reminded itself of the precise terms of this sub-paragraph, namely that Dr Lewis ‘engaged in a facetime call with Ms B in September 2016 during which he appeared to masturbate under the bedclothes.’ The Tribunal considered that this charge was ambiguous. Whilst an individual might appear to be
undertaking a sinister act, he may not in fact be doing so. In this case, although Ms B’s perception was that Dr Lewis appeared to be masturbating, her oral evidence was that she could not say whether he was in fact doing so. The Tribunal accepted Mr Gillespie’s submission that the charge, as drafted, was wholly unfair to Dr Lewis, where an adverse factual finding could be made against Dr Lewis, on the basis that Ms B thought it looked like he was masturbating, when in fact he may not have been doing so and had no intention of giving that impression.

44. Ms B’s oral evidence was vague and undermined her written witness statement, where she indicated that she could see hand movements underneath the duvet around the groin area. In her oral evidence on this point, Ms B was even more uncertain about Dr Lewis’ actions.

45. Following the alleged incident the Trust undertook an interview with Ms B on 6 October 2016, during which it was intended that she provide information as to the Facetime allegation. There was no recording in the written notes of that meeting suggesting that Dr Lewis appeared to be masturbating during the Facetime call. Ms B said that she mentioned that to Dr F but it was not recorded. Dr F made it clear in his evidence that had Ms B mentioned this he would have made a record of it.

46. In light of all these matters, the Tribunal concluded that the evidence is tenuous in character and/or, inherently weak and/or vague, as well as being inconsistent with other evidence. The Tribunal considered that the evidence, taken at its highest, is such that a Tribunal properly directed could not find the facts proved. Accordingly, the Tribunal accedes to the application and paragraph 2(h) has been deleted from the allegation.

In relation to paragraph 3 insofar as it relates to 2 (a), (b), (c), (d), (e) (i) and (ii), f (i) and (ii) and (i) – Rejected

47. The Tribunal has taken account of the definition of sexual motivation as referred to by Mr Gillespie.

48. The GMC’s case is that all of the acts contained in paragraph 2 are sexually motivated. The Tribunal considers that its’ findings in relation to these issues requires it to evaluate the documentary and witness evidence. By way of example, the Tribunal has yet to consider whether the Whatsapp messages were of a sexual nature. The Tribunal considered that there is sufficient evidence, at this stage, as to whether the acts in paragraph 2 are sexually motivated.

49. Accordingly, the Tribunal determined to reject Mr Gillespie’ submission under Rule 17(2)(g).

Conclusion
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50. In summary, having considered all the evidence at this stage and the submissions of both parties, the Tribunal has determined to:

- Accede to Mr Gillespie’s submission with respect to paragraphs 2 (e)(i) and 2 (h) and 3 in relation to 2(e)(i). Accordingly, these paragraphs have been deleted from the Allegation.

- Reject Mr Gillespie’s submission with respect to paragraphs 2(f)(i), 2(g)(iii) and 3 as it relates to 2(a), (b), (c), (d), (e)(ii), (f)(i), (ii) and (i).