GENERAL OSTEOPATHIC COUNCIL

PROFESSIONAL CONDUCT COMMITTEE

Case No: 661/2050

Professional Conduct Committee Hearing

DECISION

Case of:	Mr Michael Kern
Committee:	Mr Richard Davies (Lay Chair) Mr Alastair Cannon (Lay) Mr Kenneth McLean (Osteopath)
Legal Assessor:	Mr Peter Steel
Representation for Council:	Ms Laura Stephenson
Representation for Osteopath:	Mr Matthew Paul
Clerk to the Committee:	Mr Farhan Kabir (13 – 14 November) Ms Jemima Francis (15 November)
Date of Hearing:	13 to 15 November 2018

Summary of Decision:
Allegations 1, 3, 4, 5 and 7 (in part) admitted and found proved. Allegation 2 found not proved. Allegation 6 and allegation 7 in so far as it related to allegation 6 found proved. Unacceptable Professional Conduct found proved. Sanction imposed of removal of the Registrant's name from the Register.

Allegation and Facts

The allegation is that you, Michael Kern, are guilty of Unacceptable Professional Conduct, contrary to Section 20(1)(a) of the Osteopaths Act 1993 in that:

1. Between 30 March 2006 and 8 August 2007, Patient A attended several treatment sessions with you.

2. During one or more sessions referred to in paragraph 1 above, you groomed Patient A by:

    a. Asking her if she wanted to be held, or words to that effect.
    b. Putting your arms around Patient A when she disclosed that her father had committed suicide.

3. From 27 August to 1 September 2006, and subsequent to the establishment of a practitioner/patient relationship, you pursued and conducted a sexual relationship with Patient A. Namely, when Patient A attended a workshop in Switzerland run by you, you invited Patient A to your room on several occasions and you and Patient A engaged in sexual activity.

4. From September 2006 until summer 2007, Patient A attended sessions with you, at which you and Patient A engaged in sexual activity.

5. On 23 February 2007, you invited Patient A to your house, where you and Patient A engaged in sexual activity.

6. In early November 2008, you attempted to re-establish an improper personal relationship with Patient A by asking Patient A if she would like to come over to your house, or words to that effect.

7. Your actions as described in paragraphs 2, 3, 4, 5 and 6 above were:

    a. Not clinically justified;
    b. Not in Patient A's best interests;
    c. A transgression of professional and sexual boundaries;
    d. An abuse of your professional position.

Decision:

Admissions

1. Mr Paul told the Committee at the outset of the hearing that the Registrant admitted allegations 1, 3, 4, 5, and also allegation 7 in respect of allegations 3, 4 and 5. The Registrant also admitted unacceptable professional conduct in respect of the admitted allegations.

Preliminary matters

2. Ms Stephenson made an application that Patient A give her evidence from behind a screen. This application was not opposed and the Committee therefore agreed to it.

Submission of no case to answer

3. After the Council had closed its case, Mr Paul made a submission of no case to answer in respect of allegation 2. He told the Committee that the Council had not provided any evidence that Patient A had been groomed as alleged. Patient A had not suggested there was any flirtatious behaviour by the Registrant during the sessions she attended prior to the Swiss workshop, nor had the Registrant acted in a sexual way towards her or used sexualised language or similar.

4. In his submission, to find that there had been grooming required the Council to establish that there had been some sexual intent behind the Registrant's behaviour. The Council had not done so. It could not say that because a sexual relationship subsequently developed it must follow that the offers to hold, and the hug the Registrant actually gave her, were also sexually motivated.

5. In response, Ms Stephenson referred to the CHRE guidance, *Clear sexual boundaries between healthcare professionals and patients: guidance for fitness to practise panels*, which indicated that in cases where a Panel was considering sexual boundary transgressions, evidence of grooming might be an aggravating factor. The definition given in the guidance of grooming was "...*ie did the healthcare professional deliberately cultivate an empathetic relationship with the patient over a period of time?*" On that basis, there was evidence of grooming, namely the offers to hold Patient A which were refused, followed by the hug when she was distressed. Her submission was that these were part of a course of conduct that was intended to develop an empathetic relationship. Further, the Registrant had accepted in his response to the initial complaint that the hug had "*marked the start of me crossing an appropriate boundary* " and that he had felt "*some attraction to her* " at the time. This was more than enough evidence to satisfy the low threshold of the *Galbraith* test, in that it could provide the basis for a finding.

6. The Committee carefully considered the submissions made on behalf of the Registrant and the Council. It accepted the advice of the legal assessor. It reminded itself that the test in *R v Galbraith [1981] 2 All ER 1060* set a relatively low bar for a case to proceed. Thus if, taking the Council's case at its highest, there was some evidence on which the allegation could be established on the balance of probabilities, it should not accept the submission of no case to answer.

7. In this instance, while the Committee was careful not to form any final view on the merits of allegation 2 prior to hearing the Registrant's case, it agreed with the Council's submission that there was at least some evidence on which the allegation of grooming might be found proved. The relevant evidence related to the offers to hold Patient A during treatment, the hug, combined with the acceptance by the Registrant that the hug had crossed a boundary and that he had stated that he was attracted to Patient A at the time.

8. The Committee therefore rejected the submission of no case to answer.

Background

9. The Registrant is an osteopath who qualified in 1988 and first registered with the Council on 8 May 2000. As well as teaching and writing on craniosacral therapy (CST), he practises as an osteopath from his home [redacted] He co-founded the Craniosacral Therapy Educational Trust in 1989, which offers training, introductory seminars and advanced seminars in Biodynamic Craniosacral Therapy.

10. At the time of the matters set out in the allegations, Patient A was studying CST [redacted] She learned of the Registrant from a friend and sought treat him, not because she felt she had issues that required CST but because she was curious about the Registrant's techniques from an educational perspective.

11. Patient A first saw the Registrant as his patient on 30 March 2006. She saw him on 26 occasions for treatment between then and the summer of 2007. All the sessions took place in a therapy room in the Registrant's home.

12. It was not in dispute that between 27 August and 1 September 2006, Patient A attended a workshop [redacted] run by the Registrant. On the first day of the workshop, Patient A offered the Registrant a shiatsu massage, which he accepted. The Registrant then offered Patient A CST, which she accepted. Following this, they went to the Registrant's bedroom, where he invited her onto the bed and touched her sexually. There was no suggestion at any point that this (or any of the other sexual activity) was not consensual.

13. Following this episode, the Registrant and Patient A had further sexual encounters on each of the subsequent evenings of the workshop. This consisted of sexual touching, but not penetrative sex.

14. Following her return [redacted] Patient A next had a CST session with the Registrant on 14 S 006. Following the treatment part of the

session, Patient A and the Registrant again engaged in sexual activity. The Registrant told Patient A she did not have to pay for that session.

15. Patient A then returned to [redacted] She returned for treatment by the Registrant o n then and summer 2007, Patient A saw the Registrant regularly for treatment. Following the treatment sessions, on numerous occasions there would be sexual contact for about 10 minutes, consisting of the Registrant touching Patient A under her clothes, including her breasts and genitals and her sometimes touching his penis.

16. On one occasion, on 23 February 2007, the Registrant invited Patient A to his house. Following dinner, they went to bed and had (oral) sex. At some point during the summer of 2007, the sexual contact following the sessions ceased. Patient A last saw the Registrant for treatment on 19 September 2007.

17. These were the facts that lay behind the admitted allegations. Two matters remained in dispute. Firstly, whether the Registrant had groomed Patient A during one or more of the sessions that occurred prior to the [redacted] trip by asking her if she wanted to be held or words to that effect; and ting his arms around her when she became distressed, having disclosed that her father had committed suicide.

18. The second dispute was about whether the Registrant had sought to re-establish an improper (i.e. sexual) personal relationship with Patient A when he asked her whether she would like to come over to his house during a phone call he initiated late in the evening at some point in early November 2008.

Decision on the facts

19. The Committee heard in opening from Ms Stephenson on behalf of the Council. It heard evidence from Patient A and read carefully all the documents provided to it, including the Registrant's written response to the allegations. It also heard from the Registrant in evidence and received submissions from Mr Paul on his behalf. The Committee accepted the advice of the legal assessor.

20. In the light of the admissions made by the Registrant and the evidence presented to it, the Committee found allegations 1, 3, 4, 5 proved and allegation 7 proved in respect of allegations 3, 4 and 5.

21. As regards the disputed allegations, the Committee found as follows.

1. *During one or more sessions referred to in paragraph 1 above, you groomed Patient A by:*

    a. *Asking her if she wanted to be held, or words to that effect.*
    b. *Putting your arms around Patient A when she disclosed that her father had committed suicide.*

22. **Not Proved**. The Committee found both Patient A and the Registrant to be honest and helpful witnesses, albeit both were hindered to some extent by the passage of time since the events in question. However, their evidence coincided on many of the significant points relevant to the disputed allegations.

23. As regards this allegation, there did not appear to be a dispute that the Registrant had offered to hold Patient A at some point during the initial sessions. His evidence was that this was part of the usual process of negotiating the stages of CST treatment with Patient A, rather than an offer to give her a hug or something similar. By contrast, Patient A felt that this was an invitation to engage in a personal embrace. It was difficult for the Committee to choose between these accounts.

24. There was also no dispute that following a session during which Patient A became upset and cried, the Registrant had offered to put his arms around her and she had agreed that he do so. Patient A told the Committee that she considered that this was a "*human*" gesture, i.e. one of compassion. The Registrant endorsed this view and was adamant that there was nothing sexually motivated in the contact. He acknowledged that he now recognised that he was attracted to Patient A at the time and that this was the start of his crossing appropriate boundaries.

25. The Committee noted that there was no evidence that the Registrant evinced an intention at this point in his treatment of Patient A to encourage a personal or sexual relationship with her. He had not, for instance, attempted to communicate with Patient A outside the professional context, nor could his behaviour toward her during the initial sessions be described as flirtatious or sexualised according to the evidence heard by the Committee.

26. The Committee considered that whatever interpretation of "grooming" was adopted (and it favoured the definition suggested by the CHRE guidance referred to above) there had to be some evidence of a *deliberate* cultivation of a relationship for it to find this allegation proved. There was simply no evidence that the intent to engage in a sexual relationship with Patient A had crystallised in the Registrant's mind prior to the trip to Switzerland. On that

basis, it did not find that his offers to hold her, which were in any event ambiguous, or the hug he gave her, amounted to grooming.

6. In early November 2008, you attempted to re-establish an improper personal relationship with Patient A by asking Patient A if she would like to come over to your house, or words to that effect.

27. **Proved**. Again the evidence of Patient A and the Registrant about this allegation was broadly consistent. The Registrant had called Patient A in early November after a period when there had been no contact. The call occurred at the earliest at 9pm in the evening. The Registrant had asked Patient A if she was with her boyfriend. He volunteered that he and his partner were now separated. He invited Patient A to come to his house when she told him that she was nearby.

28. The Committee considered that the context to the invitation to come to the Registrant's house contained in this phone call was significant. The Registrant and Patient A had not communicated for some time. The last time he had invited her to his house (in February 2007), they had had sex. Indeed most of their sexual contact had taken place at his house, albeit mainly in the treatment room. Patient A felt that the Registrant had invited her to his house in order to "use" her. The Committee therefore considered it more likely than not that this was the Registrant's intention in inviting Patient A to his house. Given the exchange of emails between the Registrant and Patient A in August 2007, in which there had been at least some acknowledgment of the loss of clear boundaries on the part of the Registrant, to attempt to resume the sexual relationship was, in the Committee's view, improper. It therefore found this allegation proved on the balance of probabilities. It followed that the Committee also found allegation 7 proved in respect of this allegation.

Decision on Unacceptable Professional Conduct

29. Ms Stephenson referred the Committee to the relevant law, in particular the guidance on the meaning of Unacceptable Professional Conduct given by Irwin J in *Spencer v General Osteopathic Council* [2012] EWHC 3147 (Admin); *R(Shaw) v General Osteopathic Council* [2015] EWHC Admin 2721; and section 19 of the Osteopaths Act 1993 which set out the required approach to failures to comply with the GOsC Code of Practice (May 2005) which was in force at the time in proceedings under the Act. Mr Paul indicated that he agreed with the analysis of the law advanced by the Council. Further, the Registrant conceded that the admitted allegations amounted to Unacceptable Professional Conduct.

30. The Committee considered that the following paragraphs of the GOsC Code of Practice in force at the time were relevant: paragraph 1 ("*Trust is an essential part of the osteopath/patient relationship…*"); paragraph 2 ("*Patients must be put first…*"); paragraph 3 ("*You must not abuse your professional position by pursuing a close personal or sexual relationship with a patient or someone close to them…*"); paragraph 4 ("*It is your professional duty not only to avoid putting yourself in such a position, but also to avoid any form of conduct that may be construed as a willingness to enter such a relationship.*"); paragraph 5 ("*If you think, or there are any signs to suggest, that a close personal or sexual relationship with a patient is developing, you must stop treating the patient and end the professional relationship immediately.*"); and paragraph 62 ("*It is fundamental to good osteopathic practice that you treat patients with respect…You must never abuse this trust*").

31. The Committee accepted the advice of the legal assessor. The Committee bore in mind that there is no standard of proof and that a determination as to whether the threshold for Unacceptable Professional Conduct has been reached is a matter of judgment. The Committee had regard to Section 20 of the Osteopaths Act 1993, which defines Unacceptable Professional Conduct as conduct which "falls short of the standard required of a registered osteopath". It considered guidance from the Council and the matters set out by Irwin J in *Spencer v GOsC* [2012] EWHC 3147 that Unacceptable Professional Conduct is conduct which implies some degree of "moral blameworthiness".

32. The Committee's findings were that the behaviour demonstrated by the Registrant fell far short of the required standard of a registered osteopath. His conduct exhibited multiple departures from the Code of Practice and clearly had the potential to undermine public trust and confidence in the profession. Though the Registrant was not acting as an osteopath at the time of the events in question, he was on the osteopathic Register, was an experienced practitioner, had written about professional boundaries in a book he had published and had been involved in the education of other practitioners. He had rightly accepted that in initiating and pursuing a sexual relationship with a patient under his care he was guilty of Unacceptable Professional Conduct.

33. On his own admission, the Registrant had not only engaged in sexual activity with Patient A, but had done so repeatedly in the context of professional consultations. This was a gross abuse of his professional position. He had attempted subsequently to re-establish the relationship despite his awareness of the effect it had had on Patient A. Patient A had been left confused and distressed by the Registrant's actions. The Committee had no doubt that the

facts of the case would certainly convey a serious degree of opprobrium and moral blameworthiness to the ordinary, intelligent citizen. It therefore found that the facts and particulars found proved amounted to Unacceptable Professional Conduct by the Registrant.

Decision on sanction

34. The Committee listened carefully to the submissions of Ms Stephenson on behalf of the Council and to those of Mr Paul on behalf of the Registrant. It heard further evidence from the Registrant in mitigation. The Committee took account of all the testimonials and other material provided on behalf of the Registrant and considered the Council's Hearings and Sanctions Guidance, as well as the relevant CHRE guidance referred to previously. It noted and accepted the advice of the legal assessor, in particular as to the principles it should apply in considering sanction in a case of sexual misconduct to be drawn from the recent case of *Arunachalam v GMC* [2018] EWHC 758, which included: (i) the Committee should make and demonstrate in its determination a proper evaluation of the mitigating factors in deciding on sanction; (ii) personal mitigation counts for less than in other contexts because of the need to maintain public confidence in the profession (*Bolton v Law Society* 1994 1 WLR 512); (iii) the law did not require that in all sexual misconduct cases, removal from the Register should follow. The severity of the sanction required to maintain and preserve public confidence in the profession "*must reflect the views of an informed and reasonable member of the public*" *Giele v GMC [2006]* 1 WLR 942; and (iv) despite a zero tolerance attitude towards sexual misconduct, the law is not so inflexible that every transgression of this kind must be met with removal from the Register. The Committee carefully considered the mitigating and aggravating factors of this case.

35. Having found the Registrant guilty of Unacceptable Professional Conduct, the Committee has to decide what sanction to impose. The Committee commences at the lowest sanction, and only if it decides that sanction is not appropriate does it move to the next level of sanction. It acknowledged its obligation to apply the principle of proportionality and to uphold the public interest. The latter includes the protection of patients; the maintenance of public confidence in the profession; and upholding appropriate standards of conduct.

36. The Committee considered that the following mitigating factors were present. Firstly the Registrant was previously of good character. It noted his expression of regret and his candour in engaging with the Council in its investigation. The Committee took into account the Registrant's early

admissions to most of the allegations. The Committee also read the testimonials provided for him by a wide range of patients and other practitioners, which speak to his professional competence and good character. It noted the Registrant's account of his stressful personal circumstances at the time of the events found proved.

37. The Committee was also informed of the Registrant's self-initiated efforts to address his behaviour through therapy and further training. The Registrant had sought professional help shortly after the events in question and long before Patient A's complaint came to light. This suggested some degree of insight about his conduct. However the Committee noted that he had recognised his conduct was wrong at the time, yet he had still persisted in a sexual relationship with Patient A. Lastly, the Committee recognised that there had been no suggestion of any similar behaviour since her complaint came to light.

38. The Committee found the following aggravating factors to be present. Firstly, this case did not amount to an isolated event. It featured a deliberate course of conduct over a significant period of time. Secondly, as was plain to the Registrant at the time, Patient A was vulnerable, yet he knowingly and repeatedly engaged in sexual activity with her, notwithstanding her evident emotional distress in treatment sessions. The Committee also considered that the fact that the sexual activity occurred mainly at the end of treatment sessions, which were specifically arranged at the end of the day, suggested a considerable degree of calculation and exploitation.

39. Thirdly, the Registrant accepted in his evidence to the Committee that in prioritising his emotional needs over hers, his behaviour had harmed Patient A. As he also accepted, there was no possible excuse for such behaviour.

40. Lastly, this behaviour was a gross abuse of the Registrant's professional position, involving sexual misconduct, which was highly likely to damage the standing of osteopaths generally.

41. The Committee considered first of all whether an Admonishment was appropriate. It had already determined that the Registrant's conduct fell far short of the standard to be expected of a registered osteopath. As set out in the CHRE guidance: *Clear sexual boundaries between healthcare professionals and patients*: *guidance for fitness to practice panels*, the erosion of proper boundaries between healthcare professionals and patients is not only harmful to the affected patient, but also highly damaging in terms of confidence in healthcare professionals generally and leads to a diminution in

trust between patients, their families and healthcare professionals. The Registrant accepted that he had harmed Patient A. Such misconduct was substantial and grave. The Committee concluded therefore that an Admonishment would not meet the seriousness of the situation.

42. The Committee therefore went on to consider whether a Conditions of Practice Order would be appropriate in this case. The Committee concluded that conditions of practice would not be appropriate or proportionate to address the seriousness of the case. There was no condition of practice that would practically address the Registrant's unacceptable behaviour. In addition, the Committee was concerned that the Registrant had not demonstrated sufficient insight to merit the imposition of conditions. He had persisted in behaviour that he knew was wrong and harmful to Patient A at the time. Despite his subsequent remedial activity, the Committee was not satisfied on the basis of the evidence before it that the Registrant had eliminated all risk of his acting as a "rescuer" in future, that is, in the way he said he had in this case, with the attendant ill effects.

43. The Committee then considered whether a Suspension Order would address the facts of the situation. It concluded that it would not. Despite taking into account all the mitigation offered on behalf of the Registrant, including the numerous positive testimonials, the passage of time and the apparently successful nature of his practice subsequently, the Committee considered that the Registrant's misconduct represented a reckless and particularly serious departure from the relevant professional standards.

44. The maintenance of appropriate professional boundaries remains essential to the relationship of trust between practitioner and patient. The gross breach of trust in this case has the potential to cause great damage to confidence in the osteopathic profession generally. The Registrant's admitted and proven misconduct is fundamentally incompatible with his continued registration. The Committee considered that the public interest in this case could only be protected by the imposition of the sanction of removal from the Register and that no lesser sanction could appropriately reflect its seriousness.

45. The Committee therefore determined that the Registrant's name should be removed from the Register.

Decision on Interim Suspension Order

46. Having heard submissions from Ms Stephenson on behalf of the Council and from Mr Paul on behalf of the Registrant the Committee did not consider it

necessary for the protection of the public to impose an Interim Suspension Order. While in any case of this nature there may be at least a residual risk of reoccurrence, the Committee had not been made aware of any other complaint about the Registrant's professional practice or personal conduct. More than 10 years had elapsed since the events of this case. The Registrant's good conduct during this period of unrestricted practice was further supported by the testimonials supplied on behalf of the Registrant. The Committee therefore determined that the test of necessity in Rule 40 of the Rules was not met.

Under Section 31 of the Osteopaths Act 1993 there is a right of appeal against the Committee's decision.

The Registrant will be notified of the Committee's decision in writing in due course.

All final decisions of the Professional Conduct Committee are considered by the Professional Standards Authority for Health and Social Care (PSA). Section 29 of the NHS Reform and Healthcare Professions Act 2002 (as amended) provides that the PSA may refer a decision of the Professional Conduct Committee to the High Court if it considers that the decision is not sufficient for the protection of the public.

Section 22(13) of the Osteopaths Act 1993 requires this Committee to publish a report that sets out the names of those osteopaths who have had Allegations found against them. The Registrant's name will be included in this report together with details of the allegations we have found proved and the sanction that we have applied today.