THE HIGH COURT

[2024] IEHC 168

RECORD NO 2022 / 51 SP

IN THE MATTER OF S. 75 (1) OF THE MEDICAL PRACTITIONERS ACT 2007

BETWEEN

SAQIB AHMED

APPELLANT

AND

THE FITNESS TO PRACTICE COMMITTEE OF THE MEDICAL COUNCIL

AND

THE MEDICAL COUNCIL

RESPONDENTS

Judgment of Mr. Justice Mícheál O'Higgins delivered on the 5th day of March 2024

Introduction

1. This is a doctor's appeal of a finding of "Poor Professional Performance" following an Inquiry held by the Fitness to Practice Committee of the Medical Council under the

Medical Practitioners Act 2007. The case concerns the circumstances in which a once–off error will amount to Poor Professional Performance ("PPP").

2. The events the subject of the inquiry occurred a long time ago in November 2012. The Fitness to Practice inquiry took place on various dates in March and July 2015. The appellant represented himself at the hearing. He faced nine charges overall, some of which were sub–divided. The first respondent ("the Committee") dismissed all charges except charge 7(b) which reads as follows:

> "*On or around 6 November 2012 in respect of patient BK who was transferred from Bon Secours Hospital, Tralee, Co. Kerry, [he]:*
>
> *(b) Failed to request the following basic tests to include, but not limited to:*
>
> *(i) Blood tests; and/or*
>
> *(ii) Urine tests; and/or*
>
> *(iii) Kidney function tests".*

3. The Committee found that this allegation had been proven as to fact and that it amounted to "Poor Professional Performance" within the meaning of the 2007 Act. The Committee recommended the sanction of an admonishment, which is the second lowest form of sanction.

4. In accordance with the statutory process, the Committee sent a report on the Inquiry to the second respondent (the Medical Council) and the Medical Council decided to impose the sanction of "advice" which is the lowest form of sanction available under the Act.

5. By originating notice of motion issued on the 4th of April 2022, the appellant appealed under s. 75 of the 2007 Act, the findings and report of the Committee and the decision of the Medical Council to impose the sanction of "advice".

6. As will be apparent from the short chronology above, an interval of some six and a half years elapsed between the notification of the Medical Council's decision (September

2015) and the lodging of this appeal (April 2022). I will explain what happened in the intervening period later in this judgment. Firstly, however, I will detail the background facts leading to the Committee's decision to commence the disciplinary process.

7. The appellant, Dr. Ahmed, was born in 1980. He received his medical qualifications and initial training in Pakistan. Before he came to Ireland, he had some experience as a House Officer in General Medicine in Pakistan in 2004 and then as a Senior House Officer in General Medicine in a hospital in Oman. He applied for the position of registrar with the Oncology Department in the Midwestern Regional Hospital, University Hospital Limerick ("UHL") in May 2012. He was successful at interview and commenced his duties as a Registrar in the Oncology Department in July 2012. The appellant was then aged 32. He is now 43.

8. On the 6th of November 2012, he was on–call in UHL and was informed that a patient who was 28 years old was being transferred from Bons Secours Hospital in Tralee to the Oncology Ward in UHL that evening. As the Registrar on call, he was required to admit the patient and carry out an examination. The patient in question (B.K.) arrived later than expected at approximately 7:30 p.m. The letter of referral was from a Consultant Surgeon in Tralee and was dated the 6th of November 2012. It was addressed to Dr. Denis O'Keeffe, Consultant Haematologist in UHL. The letter recorded that the patient had been admitted to the Bons Secours in Tralee the day before (5th November) with severe abdominal pain. The letter recorded that on examination the referring surgeon could feel a palpable mass in the upper abdomen and there were enlarged lymph nodes in several areas. A CT scan of chest, abdomen and pelvis revealed a large mass in the retroperitoneal area, pushing forward the pancreas, aorta and bowel. There were also lumps in the lungs. The diagnosis was said to be widespread lymphoma. The referring surgeon indicated that the patient would need further

treatment and that the referring surgeon would organise for a biopsy the following morning if there was a delay in getting him a bed in UHL.

9. The appellant was contacted by nurses on the evening of the 6th November once B.K. had been received in the oncology ward. The appellant reviewed the patient with the staff nurses. However, he did not write up notes of his examination. It is common case that he did not undertake blood, urine or kidney function tests. The CEO of the Medical Council contends that these are "basic tests". The failure to order these tests forms the basis of the disciplinary finding that the appellant is now appealing to the High Court.

10. At some point during his dealings with B.K., the appellant was called away to see another patient who was very unwell and needed to be examined in the Accident and Emergency Department. The appellant says in his responding letter that having to deal with this other patient led him to forget to write up the notes of his examination of B.K.

11. The next morning, the locum Consultant, Dr. Fadalla, who was a Consultant Haematologist, checked on patient B.K. On the previous day, he had discussed the case with his colleague Dr. Denis O'Keeffe, who had accepted the referral from the surgeon in the Bons Secours. Dr. Fadalla attended to B.K. in the ward but was concerned that no admission notes had been written up, and it was not known what level of examination had taken place or history taken. Dr. Fadalla rang the appellant to ask him about his examination of the patient. According to Dr. Fadalla, the appellant became verbally abusive, and dismissed the consultant's concerns and the need for repeating the blood tests. Dr. Fadalla was not happy with the appellant's management of the patient.

12. When Dr. O'Keeffe, the consultant whose patient B.K. was, started on his ward round on the 7th of November, he discovered that there were no notes on the appellant's admission and examination, and learned that no blood tests had been ordered. He spoke with Prof. Gupta, the Oncology Consultant in UHL and the Regional Director for Cancer Services and

relayed that he was concerned about patient B.K. who was very unwell and had needed a lot of morphine overnight to control his pain. Prof. Gupta and Dr. O'Keeffe decided to speak to the appellant in the nursing area. That conversation became heated, so Prof. Gupta moved the conversation into a more private room. Dr. O'Keeffe asked the appellant about his examination of the plaintiff and sought explanations as to why tests had not been ordered and examination notes not written up. Again, the appellant became defensive and dismissive. Voices became raised, so Prof. Gupta brought the conversation to a close and told the appellant he should go home and that the Manager of Cancer Care Services would contact him later.

13. According to a complaint subsequently filed by Prof. Gupta with the Manager of Cancer Care Services in the Hospital, and subsequently with the Medical Council, this incident in November was one of a number of occasions when the appellant's conduct and interactions with staff and patients was called into question, during the period of July to November 2012, when he first started in the role as Registrar in UHL. This eventually resulted in the appellant facing some 9 disciplinary charges in a Notice of Inquiry, some of which related to his management of other patients.

14. However, while the prior history and lead–up to the incident is undoubtedly relevant and cannot simply be air–brushed out of the picture, it should be noted that the only disciplinary charge now before the court is the sole allegation (charge 7(b)) that the appellant failed to request blood, urine and kidney function tests for patient B.K. Save as an issue of context and background, the court is not concerned with any earlier incidents or other allegations included in the original Notice of Inquiry. All of these have now fallen away, except for allegation 7(b) relating to patient B.K.

15. It should also be noted from the outset that it is common case that the appellant's failure to order the tests in question did not cause injury to the patient and did not in fact have any causal consequence.

The nature of a s. 75 appeal and meaning of Poor Professional Performance

16. Before I address the evidence in this case in greater detail, I should firstly outline what is meant by a finding of "Poor Professional Performance" and detail the nature of a s. 75 appeal and the legal regimen that applies to the process.

17. The term "Poor Professional Performance", in relation to a medical practitioner is defined in s. 2 of the 2007 Act as:

> *"a failure by the practitioner to meet the standards of competence (whether in knowledge and skill or the application of knowledge and skill or both) that can reasonably be expected of medical practitioners practising medicine of the kind practised by the practitioner".*

18. The emphasis in the statutory definition is on the issue of a doctor's competence. The leading case on the elements of PPP is the decision of the Supreme Court in *Corbally v. The Medical Council* [2015] 2 IR 304. I will come back to the *Corbally* decision later as it is very relevant to the legal issues that arise in this case. For the moment, it is sufficient to note that the Supreme Court decided that the definition of PPP must be read as importing a threshold of seriousness which must be met before any finding of PPP can be made. The Supreme Court found that only conduct which represents a serious falling short of the expected standards of the profession could justify such a finding. It follows that not every error or shortcoming will be sufficient to cross the threshold.

19. Section 75 of the 2007 Act (as amended) provides as follows:

"*(2) The Court may, on the hearing of an appeal under subsection (1) by a medical practitioner, consider any evidence adduced or argument made, whether or not adduced or made to the Fitness to Practise Committee.*

(3) The Court may, on the hearing of an appeal under subsection (1) by a medical practitioner—

(a) either—

(i) confirm the decision the subject of the application, or

(ii) cancel that decision and replace it with such other decision as the Court considers appropriate, which may be a decision—

(I) to impose a different sanction on the practitioner, or

(II) to impose no sanction on the practitioner,

and

(b) give the Council such directions as the Court considers appropriate and direct how the costs of the appeal are to be borne".

20. The parties are agreed that a s. 75 appeal involves a full *de novo* appeal in the High Court. The appeal does not review what happened before the Fitness to Practice Committee. Rather, the role of the court is to reach its own view as to whether the allegation has been proven (see the decision of Charleton J. in *Barry v. The Medical Council* [2007] IEHC 74 and the decision of Clarke J. in *Fitzgibbon v. Law Society* [2015] 1 IR 516).

21. Secondly, it is agreed between the parties and is clear from the caselaw that the CEO of the Medical Council bears the onus of proof and that the standard of proof which should be applied is the criminal standard of proof beyond a reasonable doubt, following the decision of Keane J. in *O'Laoire v. Medical Council* (Unreported, 27th of January 1995). The 2007 Act itself does not set out the standard of proof to be applied.

22. Thirdly, while the applicable standard of proof is that of proof beyond a reasonable doubt, it does not follow that the inquiry process and the criminal process are in all respects identical. An inquiry is not a criminal proceeding (see the decision of Murphy J. in the Supreme Court in the same case, O'Laoire v Medical Council Unreported, 25th July 1997 and the decision of Kearns P. in *McManus v. The Fitness to Practice Committee of the Medical Council and The Medical Council* [2012] IEHC 350).

23. Fourthly, it is agreed between the parties that in a s. 75 appeal, the appellant is not obliged to give evidence in his defence, and that no adverse inference should be drawn from any decision not to give evidence.

Evidence in the case

24. This appeal took place over three days on the 28th and 29th November and the 12th December 2023. For the CEO of the Medical Council, the court heard factual evidence from Prof. Rajnish Gupta, Dr. Kamal Fadalla and Dr. Denis O'Keeffe. Prof. Ray McDermott gave independent expert evidence that the appellant's failure to order the tests in question constituted a serious falling short of the required standard and amounted to PPP. The appellant called one witness, Dr. Ernest Allan who gave independent expert evidence to the effect that the appellant had not committed an error in not ordering a fresh set of tests and was not, in the circumstances, guilty of PPP. The defence emphasised that the appellant had available tests results from the Bons Secours hospital from the day before and that these tests were all reported as normal. The appellant himself did not give evidence. The parties were represented by Solicitors and Senior and Junior Counsel. Each witness was examined and cross-examined and the court was also provided with a core book of documents. It was agreed between the parties that the documents could be admitted into evidence without having to be formally proved.

25. For reasons of brevity, I do not propose to outline comprehensively the evidence of each witness. Since it is the main area of dispute, I will focus primarily on the evidence of the two witnesses who gave independent expert evidence, namely Prof. McDermott and Dr. Allan. Before doing that, I will touch on a few points made by the other witnesses in the case.

Professor Gupta

26. Prof. Gupta confirmed that the patient B.K. was admitted to UHL from the Bons Secours in Tralee under the care of Dr. O'Keeffe and was ultimately to be transferred into the care of Prof. Gupta on the 7th November 2012, when the diagnosis of metastatic germ cell tumour of the testis was made. Prof. Gupta had no first-hand involvement with the patient until he was transferred to him. His involvement was confined to the meeting on ward 4B on the morning of the 7th November 2012, when he and Dr. O'Keeffe met Dr. Ahmed. Subsequently, Prof. Gupta wrote the letter of complaint to the manager of Cancer Care Services in the hospital and also to the Medical Council.

27. Prof. Gupta gave his evidence in a very fair and balanced way. He made some points in favour of the appellant's position but also stood over the finding made by the Committee and the correctness of the decision to make the complaint. He stated in his evidence that Dr. Fadalla and Dr. O'Keeffe were worried about patient B.K. who was extremely unwell and required a lot of morphine overnight to control his pain. The appellant had correctly provided analgesia for B.K. but it took one intermuscular dose of morphine and three subcutaneous doses of morphine to control the patient's pain over a twelve hour period. Unlike Dr. Fadalla, he was not concerned about tumour lysis syndrome.

28. Prof. Gupta explained the risk of administering morphine and identified that the normal practice is to ensure a patient's renal function was satisfactory, before prescribing morphine. The patient had not received morphine in the Bons Secours in Tralee but had been given some form of analgesic which was not controlling his pain. His pain had been

documented as being 8 out of 10 on a pain scale by the nursing staff. Dr. Ahmed was informed about this and had returned to the ward later that evening and wrote up a drug called cyclomorph which was administered intramuscularly and also wrote up morphine sulphate, which was given on three occasions during that night. Most doctors would be aware that morphine is eliminated from the body by the kidneys and, therefore, it is required practice to ensure that the patient's renal function is satisfactory to eliminate the morphine from the system, otherwise you would reduce the dose of morphine accordingly.

Evidence of Dr. Fadalla

29. Dr. Fadalla stated that patient B.K. was very unwell on admission from the Bons Secours in Tralee. B.K. had presented with severe abdominal pain and his scan showed a very extensive generalised lymphadenopathy which is very concerning for malignancy. When doctors see this extensive generalised lymphadenopathy, pushing vital organs, the concern usually is a high-grade lymphoma. Given the patient's young age, and in light of the abdominal lymphadenopathy, there was a very real concern that they were dealing with a very aggressive lymphoma.

30. The usual practice is for whoever was admitting the patient to write up a history of the patient, the findings on examination and also a management plan. It is the responsibility of the Registrar on call to do this. The responsibility of the Consultant is to give advice to the Haematology Registrar. If the Haematology Registrar who is on-call is in doubt about anything regarding the management of a patient during the night, they are supposed to phone their consultant on call to get advice and talk through the plan.

31. Dr. Fadalla addressed the appellant's main argument, that blood tests had been carried out the day before in the Bons Secours on the 5th November. When he reviewed the patient on the morning of the 7th November, he had the test results from those tests. He documented them when he wrote up the patient notes on the charts. However, as far as he was concerned,

they were not sufficient as they were not representative of the patient's *current* situation. Usually with an aggressive malignancy and high-grade lymphoma, doctors needed at least a blood test every day. Sometimes with high-risk patients blood tests are done twice a day. This is so that the test results represent the current and up to date situation of the patient.

32. Dr. Fadalla explained what is involved in carrying out the various basic tests. In the biochemistry test, the doctors test for the liver function, kidney function, the electrolyte in the patient's blood and for something called CRP which is a marker for inflammation or infection in the patient's body. In the context of this patient, they needed to see if there was any evidence to indicate that there was an infiltration in the liver, which can sometimes be picked up by doing the liver function test. The liver function test will also give you an idea if there is any obstruction in the ureter. When urine accumulates and goes down to the bladder, it can give an abnormal reading in the kidney function test. The CRP is very good for assessing inflammation and infection. If a patient has a very high CRP it could be an indication that the patient has infection and may need antibiotics. It also checks the electrolyte of the patient. Sometimes potassium or sodium might be low or high, and, for example, patients with high grade malignancies could have high potassium which poses the main risk of getting arrythmia (an irregular heartbeat). This can be life threatening.

33. Dr. Fadalla was cross-examined on the fact that the bloods on the system were taken as recently as the 5th November, the day before the appellant examined the patient. He said it was not sufficient to rely on the test results from the previous day. Counsel for the appellant pursued this further and the witness agreed that he himself had relied upon the test results that had been done (now two days earlier) in Tralee on the 5th November.

34. It was put to Dr. Fadalla that he had not said in his own notes, following his own examination, that he was unable to assess renal impairment. On the contrary, he had specifically noted in his notes that there was no evidence of renal impairment and in coming

to that conclusion he relied upon the test results that had been taken in the Bons Secours. Dr. Fadalla accepted this. He also appeared to accept that he had been so satisfied that there was no renal impairment based upon the CT scan and the test results of the 5th November, that he decided it was actually appropriate to increase the dosage of morphine that Dr. Ahmed had prescribed in order to deal with the patient's pain symptoms. He was critical of the dosage that the appellant had prescribed and he increased the dose of allopurinol because he felt a dose of 100mg was not the standard dose for tumour lysis syndrome. He confirmed that he would not have prescribed the higher dose of 300 mgs if there was evidence of renal impairment.

35. Separately, it was put to Dr. Fadalla that Prof. Gupta, Prof. McDermott, and Dr. Allan who was retained on behalf of the appellant, did not agree that tumour lysis syndrome was something that a registrar such as the appellant should have been concerned about in patients such as B.K. On that basis it was put to Dr. Fadalla that his concern about the significance of tumour lysis syndrome was misplaced, and therefore the alleged error did not amount to a serious falling short of the required standards. The witness disagreed and stood over his position that the test results were indicated.

Evidence of Dr. O'Keeffe

36. Dr. O'Keeffe stated that the patient B.K. was a young man and the referring surgeon was looking for a centre such as UHL to take over the patient and to get the biopsy done as soon as possible. When Dr O'Keeffe heard the history of the patient and the scan results, he was worried for the patient. He said that in the case of any doctor, whether Registrar or Intern or SHO, he would expect them to review the patient, write a note of their review and a summary, ensure that bloods were sent, and that the results of those bloods had been reviewed prior to concluding that the patient was safe until review the following morning.

37. The purpose of carrying out blood tests at admission was to ensure that the patient was stable. It is the responsibility of any doctor when a patient presents to the hospital to assess and ensure that the patient is stable until your colleagues have a chance to review the patient. You examine the patient to ensure they are not in severe pain, assess that there is no finding that triggers a significant worry that must be discussed with a consultant colleague, or any blood results that may indicate that the patient is deteriorating. B.K. was an unwell young patient with a possible high-grade lymphoma. He had a significant intra-abdominal mass with potential for acute deterioration, particularly renal failure. There is a potential for things to change very rapidly, particularly from a renal function and electrolytes perspective.

38. When it was put to him that the patient B.K., apart from being in pain, was otherwise quite well when he presented to the hospital on the 6th November, Dr. O'Keeffe disagreed. He emphasised that this was a young man in hospital with very significant disease and a potential to deteriorate very quickly. He was in severe pain in Tralee. On that basis, he disagreed with the suggestion that the patient could be described as being "well". He also disagreed that the test results from the 5th November in Tralee were sufficient.

Report and evidence of Professor Ray McDermott

39. Prof. McDermott is a Consultant Medical Oncologist with a special interest in genitourinary disease. He has practised at a consultative level in Ireland since 2004 and holds a public appointment between St. Vincent's University Hospital and Tallaght University Hospital in Dublin. He is a clinical lead of Cancer Trials Ireland and is responsible for organising and running cancer clinical trials in Ireland. He is also Clinical Professor of Medical Oncology at University College Dublin. Prof. McDermott is undoubtedly an expert in his field. He gave his evidence in a measured way and, in the view of the court, made concessions and acknowledgements where this was appropriate.

40. Professor McDermott was asked to prepare an expert report commenting solely on allegation 7(b) in the Notice of Inquiry. He was not involved in the case at the stage of the Fitness to Practice Committee Inquiry. In his report he sets out in precise terms the allegation comprised within allegation 7(b) and states his belief that, when considered together, these allegations constitute PPP. He gives his reasons as follows:

> "*Mr. B.K. was a young man referred up for diagnosis and management of a likely malignancy. The referring letter suggests that the potential for a diagnosis of lymphoma. Mr B.K. was in significant pain, requiring morphine analgesia. When such a patient is admitted to hospital, they require history taking, physical examination and up to date blood tests to include kidney function but also liver function, calcium levels, coagulation assessment and full blood count. In my view, it is not possible to make an adequate assessment of such a patient without these tests. Moreover, prior to prescribing morphine, it is important to know that there is no impairment of renal function which might lead to impaired excretion of the drug. While these tests may have been performed relatively recently in another hospital, such situations are dynamic and blood results can change significantly in a short period of time. As such, I believe that blood tests as outlined above should have been performed on admission to hospital to allow for completion of initial assessment and prescribing for pain. The consequences of the omission on this occasion seem limited. The patient was prescribed morphine and the work up for his cancer began the next day, albeit that this might have happened more quickly had the basic blood results been available the following morning for ward rounds".*

41. Breaking down each of the three sub-allegations, Prof. McDermott stated that 2 out of the 3 allegations constituted Poor Professional Performance. In relation to the first sub allegation, that the appellant failed to request blood tests, Prof. McDermott stated that an

initial assessment of a patient with a question over a new diagnosis of malignancy should include blood tests such as full blood count, liver function, calcium and coagulation. A failure to do so results in an incomplete picture for decision making, both in terms of prescribing but also as a baseline for assessing any patient's deterioration overnight.

42. In relation to sub allegation (ii), failing to request urine tests, Prof. McDermott did not believe that this allegation constituted PPP. While a urine test would be desirable in such cases, he did not believe that the failure to order it on the night of admission would materially change the management of the patient. He said a urine dipstick might give information on the presence of glucose or protein or point towards an infection. However, while desirable, he did not believe that such information is essential when making an initial assessment on a new patient such as B.K. Urine culture, while also desirable, would not yield results for one to two days.

43. In relation to sub allegation (iii), that the appellant failed to request kidney function tests, Prof. McDermott stated his belief that this allegation did constitute PPP. He gave his reasons as follows:

> "*The patient was in pain and required analgesia. Many analgesics are excreted through the kidneys, and some can impact renal function, thus, any impairment in function is important to be aware of prior to prescribing. Moreover, abnormalities in renal function are relatively common in newly diagnosed cancer patients whether through hydronephrosis, hypercalcaemia or hypovolaemia as example causes"*.

44. Prof. McDermott also provided a second report with an addendum added dated 7th November 2023 which stated the following:

> *"I can confirm that the allegations against Dr. Ahmed which I consider to amount to poor professional performance are serious".*

45. In oral evidence, Prof. McDermott confirmed that he was standing over the correctness of his two reports. He confirmed that he understood the definition of PPP, and that he had been directed to the decision of the Supreme Court in *Corbally* in that regard. He stated that when a patient is transferred under your care, you learn in medical school how to assess such a patient. You start off by taking a history. In the case of this young man with very advanced cancer on a CT scan, it would be very difficult to make an adequate assessment without having those blood tests. When a patient is under your care, you are responsible for him. If there is any deterioration in his symptoms overnight or if you are called in to see him, it is essential to have up to date information when making decisions about treatment. He was asked to comment upon the evidence of Prof. Gupta, Dr. Fadalla and Dr. O'Keeffe that this patient was very unwell. He stated that while he wasn't there on the day, a patient with that advanced cancer would be very unwell. He noted the patient's pain score of 8/10, which was entirely credible given the amount of cancer in his system. The only thing that would keep him in any way well was his young age.

46. Prof. McDermott emphasised the importance of knowing that there is no impairment of renal function which might lead to impaired excretion of the drug. The prescribing of morphine requires information in relation to renal function. Even where tests have been performed relatively recently, these situations are dynamic and blood results can change significantly in a short period of time. 24 hours in the case of someone with advanced malignancy can be a very long time and doctors need an up to date baseline. The patient had not had morphine prescribed in the Bons Secours, based on his cardex. He agreed with Dr. Fadalla's evidence that sometimes doctors do bloods on these patients twice a day because the situation can change very quickly. While it is reassuring to have the bloods from the day before, when one is assessing and taking care of the patient you need a fresh set of bloods, especially when the doctor is assuming care of the patient. He confirmed his view that the

tests in question are basic blood tests and are not, as claimed by the defence, tests that are out of the ordinary or only "urgent" tests.

47. Prof. McDermott was asked to outline his reasons for saying that the omissions on the part of the appellant are serious. He provided the following reasons:

> "*I suppose the potential consequences are very serious, so I agree that in this case happily there was no adverse outcome for the patient, but there may have been in a different set of circumstances. And I also think that this is what would be expected from a Registrar in oncology, who has been working in that job for four months at the time that he assessed this patient, and I think in that time, this was presumably not the first patient he had been asked to assess on–call and should have understood that this is how you need to assess a patient who is admitted as an emergency from a transfer from another hospital".*

48. As to Dr. Allan's suggestion that the tests should be characterised as being urgent tests and that the tests were not indicated, Prof. McDermott disagreed and noted that the patient required morphine–based analgesia. There was a significant chance that he would deteriorate at some point. The following night there was an emergency call to B.K. by the doctor on-call and he instanced that as the type of thing that can happen to such patients; they can deteriorate overnight. Doctors need all the information available to them to decide how to act. It was on that basis that he felt the tests should have been done. While ultimately the diagnosis was germ cell tumour and not lymphoma, it is the case that some lymphomas have a doubling time of 24 hours.

49. Prof. McDermott was cross–examined by Ms. Lynch SC for the appellant. He agreed it to be a common practice that the registrar who was on-call would be servicing both the haematology and oncology departments. He also agreed that it is much safer for a patient to arrive during the day when there are more people around as distinct from an after-hours

admission. That had the knock-on implication that it wasn't possible for the haematology team to review the patient at the time of the admission, and that instead he was dealt with by the oncology registrar who happened to be on call.

50. Prof. McDermott also accepted the point made by Dr. O'Keeffe that in the case of an after-hours admission, the intended local protocol was that a member of the haematology team would do a full handover to the registrar on–call. That is what Dr. O'Keeffe expected to happen. Nonetheless, the professor queried whether a formal handover would have added much to the equation, beyond what was said in the referral letter.

51. Counsel raised the question as to an underlying error contained within the original complaint. The witness accepted that the original complaint made by Dr. O'Keeffe and Prof. Gupta proceeded on the understanding that Dr. Ahmed had been specifically requested to carry out the tests. Prof. McDermott accepted that there was no evidence that that was the case but indicated, nonetheless, that that didn't change his view, that Dr. Ahmed still should have gone back to first principles and ordered the tests.

52. As to the question whether the patient was or was not "well", he accepted counsel's suggestion that judging by the blood tests from the previous day and the CT scan, patient B.K. certainly was not an *unstable* patient at the time he was transferred. He noted, however, that the patient was rated 8/10 on the pain score, which was the severe end of the scale. He accepted that when Prof. Gupta reviewed the patient the following day, he referred in a letter to the patient being "a reasonably well gentleman".

53. Prof. McDermott agreed with Prof. Gupta that the role of the registrar admitting a patient overnight is to deal with the patients until senior colleagues can carry out a review the following morning. He accepted that all that would be expected would be an overnight plan, as distinct from a full management plan for the treatment of the patient. There was no

requirement to come to a definitive diagnosis, carry out a biopsy or anything along those lines.

54. Moving to allegation 7(b) on the Notice of Inquiry, Prof. McDermott accepted that it should be viewed as a single omission, as distinct from a series of errors, even though it was subdivided into three separate parts.

55. Prof. McDermott accepted that there was no dispute but that a combination of the blood tests from the 5th of November and the CT scan showed no kidney abnormality or impairment of the renal function. However, he cautioned that they also show a very large mass in the retroperitoneum, which is very close to the ureter, which is the tube that drains the kidneys and that is a very dynamic situation. Nonetheless, he accepted it was reassuring to have the blood tests from the day before, before making decisions on medication. It was directly put to the professor that, in the overall circumstances when one has the reassurance of the test results from the day before, while it may not have been ideal for Dr. Ahmed to rely upon those blood results, it was *reasonable* for him to do so. Prof. McDermott did not accept this. Counsel probed this further and queried whether it was the professor's view that, in advance of prescribing pain medication to deal with a very significant pain score, the registrar should have taken blood, or had a nurse take blood, and then await results, which on Dr. O'Keeffe's evidence could have been a number of hours. Prof. McDermott indicated that that might be necessary. One would have to make a judgment call on that and, depending on the severity of the pain, a lower dose of morphine might be given in anticipation of getting the blood results.

56. In relation to the CEO's criticism of the decision to prescribe morphine in the absence of repeat bloods, Prof. McDermott accepted there may be circumstances where you would not wait for the outcome of the blood tests before prescribing morphine. He was asked whether, in light of the pain score of 8/10, it was reasonable in the particular circumstances

for Dr. Ahmed, in advance of getting fresh blood results which may have taken a couple of hours to come back, to prescribe analgesia by relying on the tests of the 5th November. He did not think the two matters could be separated, but said that it was reasonable in the circumstances.

57. Prof. McDermott confirmed that the decision to prescribe cyclimorph and later morphine sulphate was the correct medication for such severe pain and confirmed that he had no criticism of the way that the pain was managed.

58. Counsel then developed an interesting argument that there was an internal contradiction within the CEO's case. The gist of the argument was as follows: when the consultant Dr. Fadalla saw the patient on the morning of the 7th of November, he had been satisfied to conclude from the 5th of November test results from the Bons Secours that there was no evidence of renal impairment. So confident had he been of this conclusion, that he took the decision to increase the dose of morphine. Dr. Fadalla had stated he would not have prescribed the higher dose of 300mgs if there had been evidence of renal impairment. The CEO rejects any suggestion that Dr. Fadalla was guilty of PPP in making these decisions, even though in assessing the patient and prescribing medication, he relied (says the appellant) on the very test results the CEO criticises Dr. Ahmed for relying upon (those being the blood tests, the CT scans and renal function tests obtained on the 5th of November 2012 from the Bons Secours in Tralee). Every witness called in the case said the Tralee test results presented as normal.

59. According to the appellant, this points to a contradiction in the Medical Council's case and this theme is developed in a number of points in the transcript including on Day 1, pp. 104 – 106 (evidence of Dr. Fadalla) and Day 2, pp. 53 – 57 (evidence of Prof. McDermott) and continued at p. 82 – 83 (evidence of Dr. Allan).

60. Counsel for the appellant put it to Prof. McDermott that in circumstances where the Medical Council's own witness (Dr. Fadalla) had relied on the blood results of the 5th of November, that pointed to it being reasonable to conclude that, while it might not have been ideal or desirable, relying on the earlier test results did not amount to a serious falling short of the required standard. The professor disagreed with this and said that Dr. Fadalla was in an invidious position where he had to make a decision based on incomplete information. Moreover, he knew that the patient had already had morphine and had been OK, so it was reasonable to continue with the morphine. It was also reasonable for Dr. Fadalla to carry out the balancing exercise that he mentioned and assess the possible adverse consequence of giving the correct dose, even in the presence of renal impairment and he stated that one dose of 300mg would be unlikely to have any significant consequences.

61. Prof. McDermott agreed with Dr. Allan's view that one would not reasonably have expected the registrar to have been concerned about tumour lysis. Nor was the absence of a coagulation assessment a serious or problematic matter and it was a matter that could wait until the next morning.

62. Counsel also explored the *Corbally* test and put it to Prof. McDermott that his testimony focused upon the question whether the appellant's treatment of the patient matched up to the required standard of his peers, as distinct from the second element of the test as to whether there was a serious falling short of the expected standard. The witness responded that in his view it was a serious falling short. While he was glad that there were no consequences for the patient in question, he nonetheless believed that the failure was serious. When asked why he did not say this in his first report and had to be reminded by the Medical Council's solicitors to address the question of seriousness, the witness indicated that that was an omission on his part.

Report and evidence of Dr. Ernest Allan

63. Dr. Ernest Allan, MB, FRCR, FRCS gave independent expert evidence for the appellant. His report is dated the 25th of November 2023. The main part of the report reads as follows:

> "*That it is alleged that Dr. Ahmed was instructed to have tests performed as an urgency that evening although Dr. Ahmed refutes that this instruction was given. There is no documentary evidence that instructions were given by Prof. Gupta to Dr. Ahmed to perform blood tests… The patient was admitted as an urgency from another hospital and had not been seen by Prof Gupta. It was therefore totally inappropriate to instruct Dr. Ahmed to arrange for these tests before an assessment of the patient could be made.*
>
> *Dr. Ahmed made a reasonable decision that urgent tests were not indicated and that all necessary tests could be undertaken in the morning when the full resources of the hospital would be available.*
>
> *If the High Court makes a decision that Dr. Ahmed was instructed to arrange emergency tests the correct procedure for Dr. Ahmed to follow was to make a full assessment of the case and to decide if emergency tests were indicated. Since no other doctor at the hospital had assessed the patient, the correct procedure for Dr. Ahmed to follow was to leave all tests until he was seen by the haematologists in the morning since he had made a decision that emergency tests were not required. He should then discuss the case with Professor Gupta in the morning. In my opinion Dr. Ahmed fulfilled these requirements…*
>
> ***When tests were performed***
>
> *Blood tests to include renal function tests and electrolytes, full blood count, liver function tests, were performed on the 5th of November, the day before he was seen by*

Dr. Ahmed on the 6th of November. The CT scan demonstrating normal kidneys was also performed on the 5th November.

Dr. Ahmed was aware that these tests had been performed the previous day since he had been provided with the patient transfer letter from Mr. Francis which contained details of blood test results and the report of the CT scan…

Renal failure

The patient had a large tumour mass in the abdomen. There is a risk that this may compress the ureters and prevent renal function.

However, a renal function test performed showed no abnormality. It was thought that this test had been performed one week previously. However, a review of the documentation has revealed that the test was performed at the referring hospital on the previous day. Dr. Ahmed was aware of this normal result. A CT scan also performed on the previous day demonstrated normal kidneys and ureters indicating that kidney function would be normal. There was therefore no requirement for Dr. Ahmed to arrange urgent renal function tests.

Tumour lysis syndrome

When large rapidly progressive tumour masses are present, they may outstrip their blood supply. As a result, the tumour cells necrose and liberate their contents into the bloodstream. When this occurs, there is multi–organ failure. The condition of the patient deteriorates rapidly and there is a high mortality rate.

A blood test will demonstrate a specific abnormality. However when the abnormality can be detected the patient's general condition is deteriorating rapidly. At the emergency admission the patient was in good general condition apart from pain so that it was impossible for the patient to have been developing tumour lysis syndrome. Tumour lysis syndrome is diagnosed by a high serum of phosphate and potassium and

a low serum calcium. Tests the previous day had shown no abnormality of these electrolytes.

Urine tests

I can think of no urine test where there is an abnormality indicating a need for urgent treatment".

64. Dr. Allan addressed the criticisms of the appellant's position as made by Prof. McDermott:

"*Kidney function, liver function, calcium levels and full blood count had been performed the previous day and were normal. A CT scan had been performed the previous day. This showed normal kidneys with no evidence of tumour obstructing the kidneys.*

At 8 a.m. on the 7th November there is an annotation by the haematology consultant 'there is no evidence of renal dysfunction' [the court was told later on in the evidence that this notation had been made by Dr. Fadalla in his notes]

Coagulation defects do occasionally occur in cases of lymphoma. This is due to antibodies produced to the platelets resulting in a low platelet count with a bleeding tendency. However, the platelet count the previous day had been normal. This syndrome is rare and seldom severe. (Ref)

There was no history of bleeding.

There was therefore no danger that the patient would undergo significant bleeding during the night. Urgent coagulation studies were therefore not indicated.

Coagulation studies which were normal were performed the following day as a precaution before the lymph node biopsy".

65. In the conclusion section to his report, Dr. Allan says that he:

"*agree[s] with Prof. McDermott that it was a very aggressive tumour and that the results of investigation may change over a short period. However, they do not change overnight from being completely normal to abnormal indicating the need for urgent treatment. On admission the patient was well apart from pain. This situation is compatible with investigations being normal that was confirmed the following day. Urgent tests should only be undertaken when a patient is unwell and the cause of this is not apparent or when a life threatening condition may be developing and urgent treatment may be required. The patient was well apart from the pain that was attended to by Dr. Ahmed and there was no indication that the patient was developing a life threatening condition. In my opinion there was therefore no indication for urgent tests on the evening of the patient's arrival at the hospital.*

I have no criticism of Dr. Ahmed's management of this case.

In my opinion there is no evidence of poor professional performance …"

66. In oral evidence, Dr. Allan stated that he is now retired from practice though still engaging in providing expert evidence in cases of this nature. For some 40 years, he held the position of Consultant Clinical Oncologist at the Christie Hospital in Manchester, England. The Christie Hospital was one of the largest cancer hospitals in Europe and he and his colleagues saw patients with a variety of malignancies. He stated that the management of this particular patient – arriving "as an urgency" – is very different from the management of a routine admission. He queried the characterisation of the patient as being "unwell". He said that a patient with severe pain does not necessarily correlate with a patient in poor general condition. Patients can be in good general condition and still have pain. From the written account provided by Dr. Ahmed and from the notes from the following day, he could see no mention that the patient was actually in poor general condition. He was obviously in severe pain, but this does not correlate with poor general condition.

67. When asked whether he had any criticism of the manner in which Dr. Ahmed managed the patient over the course of the night, Dr. Allan stated that it was unfortunate that Dr. Ahmed was called away to another case so that he was unable to complete writing up the account of the patient in the notes. But apart from being unable to write in the notes, the witness had absolutely no criticism of Dr. Ahmed in the assessment and treatment of the patient.

68. Dr. Allan said he did not quite understand what Prof. McDermott meant by a "dynamic situation". He said that tumours are always progressive and some just progress faster than others. The fact that the patient, apart from the pain, was well on admission would indicate that the tumour was not, in fact, growing very rapidly. For this tumour to suddenly take off and obstruct both ureters together overnight seemed to him to be quite implausible.

69. He was asked by counsel if he agreed with the criticism of Dr. Ahmed relying on the test results of the 5th of November. He stated that he completely disagreed with Prof. McDermott in this regard and that it was reasonable for Dr. Ahmed to rely upon these results. Considering the CT scan, there was a large tumour mass present in the retroperitoneal area and certainly both ureters can be obstructed by tumour masses of this sort. But there was absolutely no sign of any obstruction whatsoever. To move from a situation overnight of producing absolutely no obstruction whatsoever to producing an obstruction so as to cause renal failure, was to his mind impossible.

70. It was very reasonable for Dr. Ahmed to rely on the blood test, the CT scan and the fact that the patient was obviously in a reasonable general condition apart from pain. Since there was no evidence of renal dysfunction, he would not have been worried about any toxic effects of the morphine. The fact that Dr. Fadalla had written in his notes "no evidence of renal dysfunction" without qualifying it in any way, indicated to him that Dr. Fadalla accepted the results of the tests and the CT scan that had been done the day before.

71. He was asked for his opinion on whether a coagulation assessment was required as part of a basic test. He said that it was not a basic test and that one should only ask for this test if there is a good clinical reason for doing so. There was no evidence of any bleeding or any petechiae and he felt that it was correct for Dr. Ahmed to leave it for the doctors on the ward the following day to decide if they wanted to do this. As it transpired, such a test was carried out and it was completely normal. The fact that other blood tests were returned as normal also tended to confirm the decision by Dr. Ahmed not to order further tests during the evening.

72. As to the question of prescribing medication and narcotics, he stated that the appellant's management of the patient's pain was appropriate and correct. The appellant started off with fairly weak analgesia but when he was informed by the nursing staff that the patient was still in pain, he decided quite rightly to start the patient on narcotics.

73. Dr. Allan disagreed with the contention that the tests in question were basic tests. He said that blood tests and kidney function tests are basic tests if a patient is admitted routinely during the day. However, they are not basic tests if patients come in "as an urgency out of hours"; in this context, there is no such thing as basic tests. Tests are only performed where indicated.

74. Dr. Allan was cross–examined by Mr Hogan SC for the Medical Council. He was asked for his understanding of the legal test in Ireland for misconduct and poor professional performance. He said if doctors have provided care or failed to provide care and patients have been damaged in any way, they should be brought before the Committee to prevent them causing any harm to patients in the future. He was asked if he considered, prior to providing his report, the provisions of the Medical Practitioners Act 2007. He said that he did not. He was asked if it followed from this that he was not aware that PPP was defined in the 2007 Act. He stated that he did not know there was a definition. Nor did he know that the

definition had been the subject of considerable judicial debate in this jurisdiction. It was suggested to him that in view of the brief given to him to provide expert evidence regarding an allegation of PPP, he should have found out exactly what that meant. Dr. Allan did not agree and said that the situation was obvious. He said the relevant question is did Dr. Ahmed fail in his duties to provide proper management for the patient which would put in him danger of an unsuccessful outcome. When it was put to the witness that he came to the situation not even knowing the actual standard that he had to apply in the circumstances in the case, he responded that he assessed the reasonableness of Dr. Ahmed's performance on the night of the clinical situation.

75. Dr. Allen was challenged on his contention that the patient B.K. was not unwell. The evidence of Prof. Gupta, Dr. Fadalla and Dr. O'Keeffe was put to the witness, all of which referenced the patient being unwell. Dr. Allan replied that, saying that a patient is well or unwell is an indefinite term and just because a patient has advanced disease and pain does not mean that the patient is unwell. The patient was well enough to go to theatre, have a biopsy and tolerate the chemotherapy. Therefore, he cannot have been so unwell.

76. He did not accept, in concluding that the medical tests were not warranted, that he had worked backwards and incorrectly extrapolated this from the fact that the patient's bloods turned out to be normal on the following days, he did not suffer renal failure and that he did not have difficulty with his kidneys.

77. It was put to the witness that the expectation on a doctor admitting a patient, as described by Dr. Fadalla, Dr. O'Keeffe, Prof. McDermott and Prof. Gupta, is that a registrar would examine a patient, take a history, and do basic tests and these steps were not reserved for special occasions or urgent cases. Dr. Allan disagreed and said that when patients are admitted as an urgency, sometimes they do require urgent investigation and treatment. Very often, it occurs that doctors panic at the referring hospital and send patients in because they

have advanced disease. However, just because such patients have advanced disease, does not mean that you have to do investigations that evening. They are basing the entire situation on whether the patient has advanced disease or in pain, and these are not criteria for sudden deterioration.

78. In re–direct, Dr. Allan was asked to clarify what kind of *indicia* of unwellness would he expect to trigger the requirement to do the blood tests that evening. Dr. Allan said that he would consider the level of consciousness, the level of lucidity, whether they had a temperature, blood pressure, and their pulse. He said that according to Dr. Ahmed [in his written response to the complaint] the patient had severe pain and was otherwise unwell. Therefore, the witness presumed that he was fully conscious, well–oriented and was able to move around.

Submissions of the parties

79. The parties provided helpful written submissions to the court and these were supplemented by way of oral submissions on Day 3 of the hearing. I will now summarise the main legal arguments made.

80. Mr. Hogan SC submitted that the CEO's evidence was framed against the backdrop of the legal test for PPP, including the requirement that the conduct complained about attain a threshold of sufficient seriousness in order to warrant a finding of a serious falling short of the required standard. The overwhelming evidence was that the tests in question needed to be carried out on admission in order to make an informed assessment of the patient and to avoid what were identified as very serious risks by Prof. McDermott because of the dynamic nature of the patient and possible rapid deterioration. Because the evidence established beyond doubt that the tests ought to have been carried out at that time, it followed that the failure to carry out the tests was a serious omission and justified Prof. McDermott coming to the

conclusion that there had been a serious falling short of the required standard. Prof. McDermott confirmed in his evidence that the potential consequences of not ordering the tests were very serious. This was supported by the evidence from the other witnesses as to fact concerning the need to have an accurate picture of renal function and to have an up to date picture when prescribing narcotics. The agreed evidence was that the prescribing of narcotics was escalated during the evening, at a time when test results probably would have been available if they had been ordered at the time of the patient's admission. Ultimately, the morphine had to be escalated from cyclimorph to morphine sulphate throughout the night in the absence of up-to-date information. That partially led Prof. McDermott to the view that the consequences could have been very serious. Decisions made by Dr. Ahmed – particularly in relation to the prescribing of narcotics – were effectively done on the blind without up to date information. This occurred in a dynamic situation in which the patient could potentially have deteriorated rapidly. Dr. O'Keeffe had been emphatic in his evidence that the results from the Bons Secours were not to be relied upon, as up to date test results were needed for a baseline.

81. As to the dispute between the expert witnesses for the respective sides, counsel submitted that the evidence of Dr. Allan was not admissible at all because of his unawareness of the test for PPP, his failure to address the issues in the case through the prism of that test, and because of the number of frailties or mistakes in Dr. Allan's understanding as to the underlying facts of the case.

82. Counsel attached particular significance to the way in which the appellant had responded to the allegations. The thrust of the appellant's argument was that the tests in question were not indicated and that therefore the decision not to carry them out did not amount to an error. That was the issue of substance in the case. The appellant's approach was not to say the tests may well have been warranted, but that the failure to request such tests did

not amount to a serious failure and, on that basis, could not constitute PPP. Neither the appellant nor Dr. Allan had opted to make that case.

83. As to the suggestion that the error could be characterised as an error of judgment and therefore engaged "fog of battle" considerations, Mr. Hogan submitted that the appellant's error amounted to a failure of competence rather than an error of judgment. The evidence established that it was expected that Dr. Ahmed would carry out these tests, because a competent registrar admitting a patient in these circumstances would have done so. This was not a case of a momentary error of judgment, rather it was a decision based upon a continued insistence that the tests were not indicated.

84. The Supreme Court in *Corbally* had concluded that the definition of PPP must be read as importing a threshold of seriousness and in particular having regard to the fact that no distinction is made in the 2007 Act between the sanctions for professional misconduct, which by long–established authority carries a seriousness threshold, and poor professional performance. A single error, if serious, or a series of errors (which may therefore be serious) can justify a finding of PPP. The Supreme Court did not accept that serious should mean "very serious" and distinguished case law in respect of the position in the United Kingdom. It was not the case that only conduct sufficiently serious to call into question a doctor's registration would be sufficient to justify a complaint or a finding of PPP. Rather, the conclusion to be drawn from the statutory scheme is that conduct which is sufficiently serious to merit public censure, admonishment or advice may constitute PPP.

85. Mr Hogan submitted that it is not required, for a finding of PPP to be made in respect of a single error, to demonstrate that actual harm has occurred, provided that the seriousness threshold was met. The question whether detrimental consequences or causative effect have occurred will be a relevant consideration but does not constitute a stand-alone requirement. In that regard, Mr. Hogan relied upon the list of 12 principles that McKechnie J. extracted from

the caselaw in this area. I will come back to McKechnie J.'s list of principles later when I consider the *Corbally* decision in greater detail below.

86. Counsel submitted that the court should not admit the evidence of Dr. Allan under s. 77 of the 2007 Act in circumstances where Dr. Allan openly conceded that he had no knowledge of the provisions of the Act, the actual meaning of PPP or the manner in which it should be interpreted. It was a *sine qua non* that a witness tendered as an expert understand what constitutes professional misconduct or PPP in relation to the practice of that profession in order to opine on the matter.

87. Without prejudice to that position, counsel submitted that if Dr. Allan's evidence was admissible, it should be accorded little or no probative value in circumstances where the witness had considered the wrong test and a materially different allegation to that actually made against Dr. Ahmed. It was submitted that Dr. Allan's evidence suffered from several frailties. He appeared to be under the mistaken impression that patient B.K. was Prof. Gupta's patient. The criticism of Prof. Gupta that was based upon this misunderstanding was misplaced and grossly unfair. Dr. Allan distinguished in his report between urgent tests and necessary tests. This is apparent as the entire premise of his opinion, and the necessity to carry out "urgent" (rather than necessary) tests, was based upon whether the patient was well or not. Dr. Allan clung to the assertion that the patient was well on admission to UHL on the 6th November, in the face of evidence from all of the factual witnesses that the patient was very unwell. The logic of Dr. Allan's position was that if a patient was well and admitted out of hours, the admitting doctor should not carry out any tests and should wait for the treating doctors to review the patient and decide what tests should be undertaken. It was on this basis that he absolved Dr. Ahmed of any failure.

88. Having regard to these and other points canvassed in the written submissions, counsel contended that the court should have no regard for Dr. Allan's evidence and should prefer the expert evidence of Prof. McDermott.

89. In summary, it was submitted that the facts underlying the allegation had been proved beyond a reasonable doubt. There was no dispute but that Dr. Ahmed had failed to request the tests. The court was then required to consider whether the failure by Dr. Ahmed to request the tests amounted to PPP beyond a reasonable doubt. For the reasons articulated, it was submitted that the court should prefer and accept the evidence of Prof. McDermott, and that the failure on the part of Dr. Ahmed was serious and constituted PPP. The threshold to be applied is "serious", not "very serious" and the court can make such a finding based on a single error or incident, in the absence of harm or injury to the patient, and notwithstanding that the appropriate sanction (such as advice) would not impact on the doctor's registration. For all these reasons it was submitted that the appeal should be refused.

Submissions on behalf of the appellant

90. Ms. Lynch SC for the appellant focussed initially on the burden and the standard of proof. The agreed position of the parties was that the burden of proof lies with the respondents to prove the allegations beyond reasonable doubt, as a matter of fact. Due to the serious consequences which potentially attend disciplinary hearings of this nature, the appellant is entitled to the presumption of innocence.

91. As to the meaning of PPP, Counsel relied upon the statutory definition under s.2 of the 2007 Act but also emphasised the principle finding made by the Supreme Court in *Corbally*. The Supreme Court found that a threshold of seriousness must be met before any finding of PPP can be made. It is now well established that only conduct which represents a serious falling short of the expected standards of the profession could justify a finding against

a doctor of PPP. The judgment of Hardiman J. in particular made clear that there are many forms of shortcoming by a medical practitioner, which, however regrettable, do not amount to a serious falling short of the expected standards of the profession.

92. While "serious" is not a term of art, it means a gravity to the conduct such as to trigger a finding which can have fundamental consequences for a doctor's constitutionally protected good name and right to earn a livelihood. Counsel relied upon the various references in *Corbally* where the Supreme Court considered the grave impact a finding of PPP would have on a medical practitioner.

93. Counsel submitted that with regards to a once-off or single event, as is alleged in this instance, the decision in *Corbally* is somewhat less clear. McKechnie and O'Donnell J.J. expressed the view that once-off events could amount to PPP if they were serious (see para. 162 of the judgment of McKechnie J. and para. 58 of the judgment of O'Donnell J.). However, these were concurring decisions and it is the decision of Hardiman J. that commanded the majority of the Supreme Court.

94. Whilst acknowledging the difference between the statutory regimes in Ireland and England, and noting that the Supreme Court had emphasised these distinctions in *Corbally*, counsel submitted that the court could obtain guidance from the judgment of *R. (Calhaem) v. The General Medical Council* [2007] EWHC 2606 wherein Jackson J. set out a number of principles regarding whether an isolated failure on the part of a consultant anaesthetist was capable of being considered "deficient" professional performance. Counsel urged that the majority decision of the Supreme Court given by Hardiman J. cited approvingly from this decision and appears to indicate a wider acceptance of the five principles laid down in *Calhaem*.

95. While acknowledging that a single event can indeed constitute PPP, counsel submitted that there is, at the very least, uncertainty as to whether such a failure must be

"very serious indeed" or must only be serious, although it was urged that the majority decision of Hardiman J. in *Corbally* supports the former approach. This issue has not been dealt with in the Supreme Court subsequent to *Corbally.*

96. Separately, counsel submitted that it is unclear the extent to which PPP must be demonstrated by reference to a fair sample of a registrant's work. This is another issue which has not been dealt with by the Supreme Court subsequent to *Corbally.* Counsel submits this should follow simply as a matter of fairness to any professional, whose performance and competence ought reasonably be judged by references to the general standards to which he or she performs, rather than by reference to a single isolated incident. It was urged that the majority decision of Hardiman J. strongly supports the view that this is a pre-requisite to a finding of PPP, save in exceptional circumstances.

97. It was submitted that on any fair view of the evidence, the appellant's appeal ought to succeed. No sample, let alone any fair sample of the doctor's work, was adduced in evidence. Instead, the respondents are asking the court to make a determination of PPP purely on the basis of this isolated event.

98. Moreover, in circumstances where PPP is alleged on the basis of a single failing, the appellant submits that, at the very least, the court must approach the allegation with considerable and critical circumspection: *"In the time-machine of hindsight, it is easy to characterise any error as serious".* Even if the court were to entirely reject the evidence of the expert that the appellant carried out his duties competently and adequately on the night in question, it will remain a truism that doctors make mistakes. They work in hectic environments. Sometimes these mistakes have adverse consequences for patients. This does not arise here because no actual consequence or injury is alleged to have occurred as a result of the appellant's alleged errors. Whilst the court must protect the public from incompetent practitioners who pose a danger to the public, it must also be alive to the context and

circumstances faced by those practising medicine, and the dangers of promoting defensive medicine.

99. The appellant also relies upon the unusual procedural backdrop to the proceedings: the lengthy interval of time that has elapsed, and the fact that multiple allegations were initially made against Dr. Ahmed, but there was now only a single allegation left on the slate. This is brought into greater focus when one considers that the original complaint relied upon a false premise communicated to Prof. Gupta, namely that Dr. Ahmed had been *requested* specifically to carry out tests and ignored that request or instruction. The appellant submits that knowing what we know now, it must be questioned whether it is likely or would ever have been reasonable to hold a Fitness to Practice Inquiry in relation to this single allegation.

100. The fact that all the other allegations contained in the Notice of Inquiry have fallen away makes this a strikingly different case to that which first came before the Medical Council when it was concerned about the doctor's ongoing performance.

101. The court should also have regard to the temporal aspect of the disciplinary charge: the only issue now is the failure to perform tests on admission, which does not include any reference to tests to be performed the next day. There was no indefinite deferral of tests: the allegation focuses on and is confined to what Dr. Ahmed was required to do on admission.

102. The circumstances in which the patient B.K. was admitted were far from ideal. He was admitted at 19.30 on the 6th November 2012 – it was after hours, and many doctors senior to him had left the hospital. The other point of context is that Dr. Ahmed was straddling two departments at the time, as he was serving as the registrar for both the oncology and haematology departments. Nor was there any evidence of a handover or direction being given to him on the night.

103. The appellant accepts that blood tests and kidney function tests were not taken on the night of the 6th November. Dr. Ahmed's main function on the night of admission was to

clinically assess the patient, and make sure B.K. was safe, stable and pain free, which he did. He relied on tests from the day before and made a clinical decision that the patient did not need further testing. In relation to the alleged failure to carry out urine tests, the CEO's evidence under this heading had fallen away.

104. As to the criticisms of Dr. Allan's evidence as made by the Medical Council, Counsel said that experts are qualified in their own discipline and are not legal experts. Dr. Allan was an extremely well qualified expert just as Prof. McDermott was, and his expert opinion was clearly formulated on the central and net issue of dispute between the parties. Given his very clear view that the appellant performed competently, the fact that he may not have been entirely across the 2007 Act, or the *Corbally* decision was, it was suggested, irrelevant. Given his clear view, the question of PPP entirely fell away, and it was not necessary to consider the second issue as to the alleged seriousness of the allegation.

105. Separately, it was submitted that, even if the court prefers the evidence of Prof. McDermott and is satisfied beyond reasonable doubt that the appellant performed sub-optimally, any once-off error on the appellant's part does not reach the threshold for PPP as required by law. The court simply could not be satisfied that this alleged single error, which had no consequences, could come within the type of error which Hardiman J. in *Corbally* would have considered sufficient to properly ground a finding of PPP, given the fundamental consequences of such a finding on the appellant's livelihood, and the absence of any other evidence which would call into question his competence.

106. In conclusion, it was contended that the allegation of PPP has not been made out on the evidence, particularly the seriousness element as required by *Corbally.* In all the circumstances, the CEO has failed to prove his case and the single finding of PPP currently staining the appellant's otherwise unblemished record ought to be cancelled.

Unusual Procedural Journey

107. In the written submissions of the Medical Council, reference is made to the fact that the appellant previously brought a judicial review to challenge the findings and report of the Fitness to Practice Committee and the decision of the Council to impose the sanction of advice. The appellant also challenged the constitutional validity of ss. 71 and 75 of the 2007 Act. The High Court (Meenan J.) held that there was no basis for granting any of the judicial review reliefs sought and he dismissed the proceedings ([2018] IEHC 75).

108. The appellant appealed to the Court of Appeal, but the appeal was unsuccessful ([2021] IECA 214). The Court of Appeal concluded that there was sufficient evidence before the Committee for it to reach a factually sustainable conclusion, that the facts of allegation 7(b) were proven against the appellant and that they amounted to PPP. The court also found that the decision and the sanction were rational, reasonable and proportionate. The appellant sought leave to appeal to the Supreme Court. The Supreme Court declined to grant leave to appeal in respect of the grounds which related to the findings and decision of the Committee and the Council. The sole grounds upon which the Supreme Court gave leave to appeal related to the constitutional validity of the impugned provisions of the 2007 Act and the compatibility of those provisions with the obligations of the State under the European Convention of Human Rights.

109. In the current case, the Medical Council has not sought to make any argument that the appellant's unsuccessful outings before the High Court and Court of Appeal constitute a legal block on the appellant bringing forward this appeal. Nor has any argument been made (correctly, in my view) that the appeal is out of time or that the appeal somehow constitutes an abuse of the process.

110. The explanation for this, and the reason why Dr. Ahmed took this unusual procedural journey was because, at the time of the Fitness to Practice Inquiry, if the Medical Council

decided to impose any of the sanctions provided for at s. 71 (b) – (g) the medical practitioner was entitled to appeal such a decision to the High Court. However, at that time, no appeal lay against the decision of the Council to impose the sanctions of "advice or admonishment, or a censure, in writing" under s. 71 (a) of the Act.

111. By the time the appellant's appeal to the Supreme Court came on for hearing, s. 75 of the Act was amended to include an appeal in respect of minor sanctions. The appellant settled the appeal to the Supreme Court on the basis of it being agreed that the section which brought about that amendment would be commenced and the appellant would be served with a fresh notice of the decision of the Council to impose sanction, thereby giving the appellant a "within–time" opportunity to appeal the decision to the High Court. As discussed at the beginning of this judgment, this appeal now involves a full *de novo* merits appeal where the evidence is heard afresh.

Analysis

112. In this case, the parties have called competing expert evidence to support their respective cases. Section 77 of the 2007 Act enables the court in an appeal of this nature to have regard to the evidence of any person of good standing in the medical profession as to what constitutes professional misconduct or PPP in relation to the practice of medicine. In accordance with s. 77, the Medical Council has called Prof. McDermott and the appellant has called Dr. Allan. The test for determining the existence of PPP involves comparing the registrant's conduct to expected standards within the profession. The central plank of the prosecution's case is Prof. McDermott's evidence concerning: (a) what the expected standard was; (b) whether there was a failure to meet that standard; and (c) whether that failure amounted to a serious falling short of the required standard ("the seriousness threshold").

113. The appellant is under no obligation to call evidence or to give evidence himself. In this case, he has chosen not to give evidence, but he has called expert evidence from Dr. Allan. Dr. Allan's evidence addresses (a) and (b) above but does not, in express terms, address issue (c) above, namely the seriousness threshold.

114. The appellant's approach and response to the disciplinary charge from the outset has been to deny any error on his part and to insist that no tests were indicated or warranted at the time of B.K.'s admission. In fairness to his position, I note from the original Notice of Inquiry that the appellant successfully defended some eight other substantive charges, some of which were further sub–divided and others of which involved the treatment and management patients other than B.K.

115. An aspect that is less complimentary of the appellant's position, however, is the way in which he reacted to the initial efforts of Prof. Gupta, Dr. O'Keeffe and Dr. Fadalla to discuss their issues of concern and seek from him some explanation why the notes of his examination of patient B.K. were not written up. The absence of any examination notes for the patient meant that the consultants were left in the dark as to what decisions the appellant had made in relation to the patient and why those decisions had been taken. In the circumstances, I think it was reasonable, and entirely to be expected, that the consultants would wish to speak to him the following morning, particularly where no notes of the examination had been written up, no phone call had been placed to Dr. Fadalla, and the patient had been in such pain that he needed to be given morphine overnight.

116. As to the heated conversation that took place with Dr. Fadalla over the telephone the next morning, and the separate conversation that took place between Prof. Gupta, Dr. O'Keeffe and the appellant in–person, I am entirely satisfied from their evidence that the appellant became defensive and reacted badly to being asked questions about his management of the patient. I accept the evidence of Prof. Gupta and Dr. O'Keeffe (which is

not contradicted) that the appellant became irate and somewhat aggressive when asked about his management of the patient, and that this resulted in bringing the meeting to a close. I have little doubt that, for whatever reason, the appellant was disinclined to accept correction and failed to accord to his colleagues' sufficient respect and courtesy. All of this is most unfortunate and does not speak well for the appellant's position.

117. I am also satisfied from the totality of the evidence that it was an error on the appellant's part not to order the tests in question, as referenced in allegation 7 (b). I accept the evidence of Prof. McDermott that in the circumstances of this patient's admission, it was necessary and appropriate to order the tests. B.K. was a young man in his twenties who had been referred to UHL for diagnosis and management of a likely malignancy. According to Prof. McDermott's evidence, the patient had enlarged lymph nodes throughout his body. The letter from the referring surgeon suggested the potential for a diagnosis of lymphoma. The evidence establishes that patient B.K. had pressure symptoms and other problems. The nurses' records, as I have mentioned, recorded a pain score of 8/10. Such was his level of pain that the appellant, correctly, prescribed morphine. A CT scan showed a large mass in the retroperitoneal area, which is a space behind the abdomen. This was impinging on the patient's organs and causing pain.

118. Prof. McDermott gave evidence that 24 hours in the case of someone such as this patient, with what was thought to be advanced malignancy, can be a very long time. Hence it is desirable to have up to date blood, urine and renal functional test results so doctors have a baseline from which to work and can react more easily and decisively in the event of a deterioration. I accept Prof. McDermott's evidence that the tests in question are "basic" tests, and in the circumstances of this particular patient, should have been performed on admission.

119. Insofar as Dr. Allan's evidence disagrees on this issue, I prefer the evidence of Prof. McDermott for several reasons. Firstly, the witness should have acquainted himself with

knowledge of the test in this jurisdiction for PPP. After all, he was being asked to opine on whether the appellant's conduct did or did not constitute PPP. Had he done so and, in particular, had he acquainted himself with the "seriousness" requirement as laid down by the Supreme Court in *Corbally*, he might well have devoted a part of his report to treatment of the seriousness threshold, which in my view would have been a more profitable focus. The fact that the witness was unaware of the statutory test in this jurisdiction, had no knowledge of the provisions of the 2007 Act, and appeared to be of the view that the legal position was irrelevant, was concerning and meant that Dr. Allan's otherwise valuable evidence lacked the necessary framework. Medical experts offering opinion evidence are not required to be walking repositories of statutory sections or legal caselaw, but they should I think have a proper understanding of the legal test in this jurisdiction for PPP within which to frame their evidence to the court.

120. Secondly, Dr. Allan accepted that the blood and kidney function tests were basic tests if a patient was admitted during the day, but that they were not basic tests if the patient "came in as an urgency out of hours". With respect, I do not see the logic of that distinction. In my view, either the tests are warranted for a particular patient's medical needs, or they are not. While it may not always be necessary to order tests on admission, in this particular case there was considerable concern about this patient, and a detailed referral letter had been sent which raised concerns and identified this patient as someone for whom baseline and up to date information was clearly going to be necessary.

121. Thirdly, all 3 consultants from UHL who gave evidence were agreed that the tests in question were warranted in light of this particular patient's circumstances. While some of the witnesses differed as to their reasoning, none of the consultants suggested the tests were not warranted. All 3 consultants were of the view the patient was very unwell. This point was disputed by Dr. Allan, but I found this aspect of the defence case to be somewhat strained.

While I take the point that the patient's vital signs appeared to be stable, I accept Prof. McDermott's evidence that in a dynamic situation with a patient with advanced malignancy who is in significant pain, doctors need an up to date baseline so that they can react quickly and decisively in the event of a deterioration. The capacity for things to deteriorate quickly for a patient such as this was a very real concern. Moreover, based on the totality of the evidence, I do not accept that the necessity to order the tests in question was restricted to patients who are likely to suddenly deteriorate.

122. In this case, the appellant took the (correct) clinical decision to prescribe the patient morphine. He also (diligently) returned to the ward later in the night to increase the dose. I accept Prof. McDermott's evidence that the prescribing of morphine requires information regarding renal function. Patient B.K had not had morphine administered in the referring hospital. The appellant, having examined the patient, and having learned of the nurses' reported pain score of 8/10, came to the clinical view that morphine should be prescribed. All of this speaks to the necessity of having up to date test results and information available in the case of a patient such as this.

123. There are also some factual mistakes in Dr. Allan's report which are referenced more fully in the Medical Council's submissions. These frailties necessarily impact the weight to be given to his evidence on certain points. In his report he criticises Prof. Gupta for ordering the tests in question without examining the patient. This criticism was completely unfounded because patient B.K. was not Prof. Gupta's patient. Nothing particularly turns on this, but it was a criticism that should not have appeared in the report.

124. For all these reasons, I prefer the CEO's evidence on the issue as to whether the tests in question were warranted in the circumstances of this patient. However, that is not to say that I found Dr. Allan's evidence unhelpful. On the contrary, I found Dr. Allan's evidence of considerable assistance in contextualising the allegations facing the appellant, and crucially in

assessing the potential seriousness of the appellant's alleged omissions. In my view, many of the criticisms of Dr. Allan's evidence contained within the Medical Council's submissions were over-stated. I do not accept that his evidence was inadmissible or meaningless, but found his evidence helpful on what I regard as the key question as to how to assess or calibrate the seriousness of the appellant's error in not ordering the tests. While Dr. Allan did not deal with the issue on a layered basis by expressly focusing on the seriousness requirement, separate and apart from the question as to whether the tests were warranted, nonetheless I found his evidence of assistance in identifying the factors which mitigated the seriousness of the appellant's error.

125. Drawing on his many years of service and expertise as a consultant in England, and over 40 years experience as a Clinical Oncologist in one of the largest cancer hospitals in Europe, Dr. Allan gave valuable evidence to the court on the expectations of a registrar in the appellant's shoes and provided important context on how the court should view, in an overall sense, the appellant's management of the patient's care. Dr. Allan assisted the court by providing relevant evidence on the appellant's overall performance of his clinical duties.

Seriousness element

126. I now turn to what I regard as the nub of the case, namely the question whether the appellant's error in not ordering the tests in these particular circumstances is sufficiently serious to warrant a finding of PPP. As with the other elements of the case, I must keep to the forefront of my mind that the Medical Council bears the burden of having to prove the allegation to the criminal standard of proof beyond a reasonable doubt. The onus is on the Medical Council to negative "every reasonable hypothesis consistent with [Dr. Ahmed's] innocence of the allegations against him" (*O'Laoire v. Medical Council, High Court*).

127. It is accepted by the respondents therefore, and further established by *Re: M, a Doctor* [1984] IR 479 at pp. 483–484 that when a practitioner exercises his right of appeal to the High Court "*the onus of proving the alleged misconduct of the practitioner rests on the Council – as does the onus of establishing that the decision made by the Council with regard to the appropriate penalty is correct".*

128. The requirement of the respondents to prove cases beyond reasonable doubt has important practical consequences where there is a conflict of expert evidence. The law as to the burden of proof and the requirement to prove factual matters to the criminal standard means that where two views are possible on the evidence, the court must adopt the view that is more favourable to the registrant, unless the other view has been established beyond reasonable doubt. Borrowing from the criminal law for a moment, Hardiman J. in *People (DPP) v. Cronin* [2003] 3 IR 377, emphasised that where two opposing views are open on the evidence, the accused is entitled to have the inference most favourable drawn, even if the favourable inference is relatively unlikely, unless it is excluded by the prosecution beyond a reasonable doubt. This is the case even if the fact-finder considers the more favourable inference much less likely on the evidence.

129. This is how Hardiman J. explained the position in *Cronin:*

> "*There is no doubt… that it is an inadequate statement of the law to say that the inference most favourable to the accused is to be drawn only where there are two or more conclusions which, with equal plausibility, can be drawn from a particular set of facts. The accused is entitled to have the inference most favourable to him drawn unless it has been excluded by the prosecution beyond reasonable doubt. This is unaffected by the fact that the jury may consider the more favourable interference much the less likely of those available. It is, of course, true that where there are two conclusions of equal plausibility, the accused is entitled to have the one most*

favourable to him drawn, but that is not the whole story: he continues to have this entitlement, even if the favourable inference is relatively unlikely, unless it has been excluded beyond reasonable doubt".

130. Applying that dictum to the facts of this case, even if the court generally prefers the evidence of Prof. McDermott over Dr. Allan on the question whether or not the tests were warranted, the finding of PPP should be set aside unless the court has no reasonable doubt that the legal threshold for PPP has been met, including the important second element of proving beyond reasonable doubt that this once–off error constituted so serious a falling short of the expected standards of the profession as to warrant a formal disciplinary finding against the doctor concerned. It is quite clear from the case law that a falling short of the professional standard set for medical professionals is not enough. Rather, the error must be shown to attain a level of seriousness such as to trigger a finding which can have fundamental consequences for a doctor's constitutionally protected good name and right to earn a livelihood.

Test results – seven days old or one day old?

131. A key factual issue in the case, and one that has caused me some concern, is the question as to the appellant's understanding of the date of the Bons Secours test results. Everyone is now agreed that the test results from the referring hospital were dated the 5th of November and timed 15:46 in the afternoon. In other words, they had been taken the day before the patient was transferred. It is common case that the tests were relied upon by both the appellant and Dr. Fadalla. However, an issue that is not agreed is the appellant's own knowledge or understanding as to the date of the Bons Secours tests. In this regard, on day 3 of the case, at the legal submissions stage, and in fact after counsel for the appellant had concluded her submissions, counsel for the Medical Council raised the issue as to the appellant's understanding of matters and submitted that the court should take into account

what the appellant appears to say in his initial response to the allegation, namely that the test results had been carried out a week previously, and not the day before. In making that submission, counsel relied upon two letters that the appellant had sent to the Professional Standards Section of the Medical Council (email of the 16th of December 2012) and to the Cancer Services Manager of UHL (email of the 20th of November 2012). This was undoubtedly an important issue because it formed a major plank of the defence case that there was no burning need to refresh the tests because they had been taken the day before. The issue was relevant not just to the question whether it was an error not to order fresh tests, but also to the second issue as to the *seriousness* of the error in not ordering such tests.

132. The other reason the issue is important is because the appellant's own expert, Dr. Allan, acknowledged in evidence that if the tests had actually been performed a week before admission, fresh tests should have been carried out when the patient was being admitted. It should be noted, however, that when the issue as to the appellant's understanding of the date was raised by counsel for the Medical Council in his replying submission, counsel for the appellant immediately objected and made the point this had not been put to witnesses during the course of the evidence.

133. Since the hearing, I have had a further opportunity to review the transcript and it does strike me that the case as mounted by the Medical Council proceeded on the basis that everyone understood the tests had been taken on the 5th of November, i.e., the day before. The following entries on the transcript are germane:

- Evidence of Prof. McDermott, Day 2, Q. 84 and Q. 86, p. 30 and Q. 90, p.31;
- Evidence of Dr. Allan, Day 2, Q. 253, p. 80/81, and Q. 270, p. 86;
- Evidence of Prof Gupta, Day 1, Q. 54, p. 56;
- Evidence of Dr. Fadalla, Day 1, Q. 159, p. 91, and in cross – examination, Day 1, Q. 193, p.103;

- Evidence of Dr. O'Keeffe, Day 1, Q. 292 – 295, p. 132.

134. It seems to me that on a fair reading of the transcript, the CEO's case proceeded on the basis that the appellant's conduct should be measured against the backdrop that when he was admitting the patient, he had results available to him from the day before. The failure that was alleged against him in this hearing, and which was addressed by the witnesses, was the failure to order fresh tests in circumstances where the existing results were a day old, not seven days old. The cross–examination carried out by the appellant's counsel of prosecution witnesses was predicated on the assumption that the criticism facing the appellant was the failure to renew the test results that were a day old.

135. In the view of the court, the entries in the appellant's responding documents that refer to the test results being a week old are concerning entries because, certainly on one view, they tend to indicate a misunderstanding on the appellant's part as to the actual date of the tests, and therefore elevate the potential culpability of the error. In the particular circumstances of the case, however, I have come to the conclusion that it would be unfair to allow the Medical Council to introduce this issue at this stage of the proceedings. In coming to that view, I am influenced by the decision of Kearns P. in *McManus v. Fitness to Practice Committee*, where the former President quashed findings made by the FTPC on fair procedure grounds, including the point that the registrant's legal team were deprived of an opportunity to mount a different form of cross–examination of key prosecution witnesses. Kearns P. accepted, albeit on more extreme facts, that different decisions as to the strategy and conduct on the defence might have been made, had it been apprehended that the Committee would switch from the opinion of its own expert and substitute in its place the view of a witness as to fact who was also the complainant. As Kearns P. noted, the importance of adhering scrupulously to the requirements of fair procedures is central to the

proper conduct of disciplinary processes which may result in serious sanctions for the person who is the subject matter of the process.

136. While the facts of the present case are very different to the facts of *McManus*, it is noteworthy that the decision of the FTPC in that case was ultimately quashed on the basis that the right of cross–examination should be free and unrestricted and not undertaken under a mistaken assumption created by the Tribunal, and for which the appellant is not responsible. Applying that principle by analogy here, I take the view it would be unfair to allow the issue as to the appellant's understanding as to the date of the tests to be introduced at this late stage of the proceedings.

137. Separate and apart from the fair procedures point, I regard the issue as to whether the appellant thought the tests were one day or seven days old as an issue of fact for the Council to prove to the required standard of proof. Since in any event I have a reasonable doubt on this net issue, applying the *Cronin* principle, the appellant is entitled to the benefit of that doubt. For these reasons, the appellant's error falls to be assessed against the backdrop that the prosecution case is that he believed the test results were a day old, not seven days old. This conclusion, in my view, necessarily has implications for the proper characterisation of the seriousness of the error concerned.

Is there a gap between *de minimis* errors and serious errors?

138. In *Corbally*, McKechnie J. provided the following guidance as to the criteria for a finding of PPP:

> "*(1) The term "poor professional performance" has a threshold of seriousness built into it: therefore, only conduct or activity, by act or omission, which reaches that level, can be said to meet the test.*

(2) This threshold applies whether the allegation be one of singularity or as involving more than one incident or activity.

(3) There is no different and by implication a more serious test, for an isolated incident such as "very serious" or "grave" or words of similar description: such is not justified by the statute nor is it necessitated in the public interest: to require the same would simply add confusion.

(4) Evidently in the normal course of events, it will be more difficult to meet the test if there is but one incident alleged.

(5) Conduct which can truly be described as trivial, minor or which can be classified as de minimis, will not qualify.

(6) Whilst outcome, detrimental consequences or causative effect are not essential, where present will be factors for consideration.

(7) Negligent acts or contractual breaches may or may not qualify: circumstances and context will determine.

(8) A finding of poor professional performance does not depend on an assessment of a representative cross section of a practitioner's work, or as has been put, on the application of a "fair sample" test.

(9) Such type of evaluation is appropriate for the purposes of the provisions of Part 11 of the 2007 Act: when invoked and where, despite opportunity having been given, the practitioner's standard of competence remains below the required level, the Medical Council can make a complaint: only at this point does the requirement of fair sample, intersect with, the disciplinary provisions.

(10) Subject to such link however, this process is entirely separate and distinct from the making, investigation and adjudication of a complaint made under Parts 7 - 9 of the Act.

(11) A finding of poor professional performance does not depend on conduct which impairs a practitioner's fitness to practise, or which calls into question his resignation.

(12) This equally applies to a finding of professional misconduct, although in either situation such finding may, but does not necessarily have to, have such effect".

139. Counsel for the appellant puts forward an interesting legal argument, relying on English case law, that a once–off failure must be "very serious indeed" in order to constitute PPP. Reliance is placed upon the majority decision of Hardiman J. in *Corbally* where he cited approvingly from the decision in *R. (Calhaem) v. the General Medical Council.* In that case, Jackson J. stated that a single instance of negligent treatment, unless very serious, would be unlikely to constitute "*deficient professional performance"*. Jackson J. also stated that a single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions. He did acknowledge however that a single omission, if particularly grave, could be characterised as misconduct.

140. As against that, in their judgments McKechnie and O'Donnell JJ. expressed the view that once–off events could amount to PPP if they were serious, and both judges emphasised that the *Calhaem* decision had to be viewed in the context of the very different statutory code that applied in England.

141. It seems to me that I do not have to determine the legal issue that the appellant raises under this heading, concerning whether there is uncertainty as to whether a once–off failure must be "very serious indeed" or must only be serious, in order to justify a finding of PPP. In my view, that issue should be held over for determination in an appropriate case where it is necessary to decide it. For the purpose of this judgment, I am going to proceed on the basis that once–off events can amount to PPP if they are found to be serious. The key issue is the

question whether the once–off error committed by the appellant here does or does not attain that threshold.

142. Looking at no. 5 in McKechnie J.'s list of principles in *Corbally*, nobody in the case before me advanced the argument that the appellant's error was trivial, minor or *de minimis*. But the question arises whether there is a gap between errors which are trivial, minor or *de minimis* on the one hand, and errors which are serious, on the other. In my view, there must be. Not every non–trivial error will be sufficient to warrant a finding of PPP. There will be cases where medical practitioners commit non–trivial errors, but which are not sufficiently serious to warrant the bringing of disciplinary proceedings. The facts of the present case support this conclusion. The report of the FTPC records that, with respect to several of the charges, the facts underpinning the charge were found to be proven beyond a reasonable doubt, and yet the conduct in question was found not to amount to PPP. This is suggestive of a built-in understanding that even in the case of errors which are more serious than trivial errors, a disciplinary finding of poor professional conduct may not be warranted. With respect to a number of the allegations on the original Notice of Inquiry, the facts were found to be proven as to fact, but yet no finding of PPP was entered. This was the outcome with respect to the following charges:

- Allegation 2 (b): that the appellant prescribed medication which was at an inadequate dose given the patient's condition;
- Allegation 2 (c): that the appellant requested a chest x–ray for patient B.R. when he ought to have known patient B.R. was too ill to be taken for an x–ray;
- Allegation 2 (j) the allegation that the appellant responded in a verbally abusive and/or aggressive manner when another doctor spoke to him about his treatment of patient B.R.;

- Allegation 3 (b) that despite being shown to use a pen to mark the area for the procedure by a particular registrar, the appellant continued to mark the area on the patient' skin with his thumbnail;
- Allegation 5 (a) that the appellant failed to respond to one or more attempts made by the hospital staff to contact him;
- Allegation 5 (b) that the appellant failed to attend a ward round in the morning with Dr. Fadalla, locum consultant haematologist;
- Allegation 7 (a) that the appellant failed to record one or more of the following in patient B.K.'s medical records:

  (v) an assessment of patient B.K.'s condition;

  (vi) a medical history in respect of patient B.K.; and/or

  (vii) an examination of patient B.K.; and/or

  (viii) a plan for treatment of patient B.K..
- Allegation 8 (b) that the appellant responded in an angry and/or aggressive manner to Prof. Gupta and/or Dr. Denis O'Keeffe and/or Dr. Kamal Fadalla.

143. The fact that these allegations were found to be proven but were not such as to warrant findings of PPP supports the conclusion that within the overall spectrum of errors, there is a gap or space between trivial/minor/*de minimis* errors on the one hand, and serious errors on the other. Some of the cases referenced by Jackson J. in the *Calhaem* case also support this conclusion.

144. The following passage of Hardiman J. in *Corbally* is also highly relevant to this issue:

"*In an ideal world no-one would make any errors, least of all a person with the responsibilities of Professor Corbally. But we do not live in an ideal world. Errors are made every day. Usually, as in this case, they have no consequence, or certainly no serious or lasting consequence. It would be a very confrontational, legalistic, and*

defensive world indeed if a person in any occupation could be put on risk of his livelihood and his irreproachable reputation because it could be proved he had made some error even (if the Medical Council is correct), one which is not serious. Any work environment where that rule prevailed is one whose work would be done very slowly, indeed unnaturally so, and staffing levels would have to be correspondingly greater than at present.

50. For the reasons set out in this judgment, I would uphold the order of [Kearns P]. Specifically, I consider that before a medical practitioner can be subjected to the extremely threatening ordeal of a public hearing before the Medical Council, either for professional misconduct, or for poor professional performance, there must be reason to believe that what can be proved against him is something of a serious nature. As I have said earlier in this judgment there may be myriad matters which are plainly not "serious" in the sense I have explained but which may legitimately aggrieve a patient or his or her relatives. But the statutory authority for the governance of the Medical profession must be capable of saying to such a person that a complaint, perhaps legitimate in itself, will not proceed to the point of an inquiry before a Fitness to Practice Committee unless it is, in its nature, a serious act or omission.

There are, both in the 2007 Act, and elsewhere, various private non-accusatorial, non-adversarial strategies available to ensure high professional standards. This reflects the fact that not every shortcoming, and in particular not every "once-off" shortcoming must either be ignored entirely or, if noticed at all, be the subject of a full hearing before a Fitness to Practise Committee". (emphasis added)

145. Returning to the facts of the present case, it seems to me that there are a number of factors which have a bearing on the question whether the appellant's omission to order the

tests in question attains the required level of seriousness to warrant a finding of PPP. I will first consider the aggravating aspects, which may be said to elevate the seriousness of the error. Firstly, the fact that the appellant made no notes of his examination of patient B.K. was very unsatisfactory. After all, this is what prompted the initial concerns of Dr. Fadalla and Dr. O'Keeffe. The consultants on the ground did not know what decisions had been taken regarding the patient's condition and management and the appellant should have been open to discussing his management of the patient when his senior colleagues contacted him.

146. A second consideration weighing in favour of a seriousness finding is the point that the appellant's error goes to the question of *competence* rather than a once–off judgment call. This is because the appellant's unyielding position was that fresh tests were not required *at all*. In other words, the logic of the appellant's position was that, were the same situation to arise in the future, he would do the same thing again and not order fresh tests.

147. A third factor pointing in favour of a conclusion of seriousness is Prof. McDermott's point that the error in question could have had very serious consequences, particularly in the case of a patient with this level of cancer in his system. This was the main reason given by the witness for characterising the failing as serious. This point has limitations, however, because there will sometimes be errors which carry the potential for serious consequences, but which do not ultimately amount to a serious falling short of professional standards.

148. It seems to me that, weighing against these aggravating features, there are a number of factors to be taken into account on the *mitigation* side of the scales. Some of these are general points, others are more specific to the case. These mitigating points include:

i. this was a once–off error;

ii. the error was not based on a pattern or sample of the appellant's work;

iii. there was no consequential injury or effect;

iv. the disciplinary prosecution proceeded on the basis that the appellant had at his disposal the test results from the previous day. This would have been reassuring to the appellant and in my view mitigates the extent or level of culpability of the error;

v. contrary to the initial understanding, the error did not involve a deliberate *refusal* to carry out the tests;

vi. the appellant did not stand to gain from the error and nor did it involve lazy avoidance of work or conscious disregard of a patient's care needs;

vii. a relevant but not dispositive factor is that it is agreed the error did not warrant any greater sanction than a censure, the lowest of the available sanctions. This does not preclude a finding of PPP, but it does qualify the nature of the error.

viii. taken at its height, the error in question was not so serious as to endanger the appellant's registration. *Corbally* makes clear that a finding of PPP does not depend on conduct that impairs a practitioner's fitness to practice, though such findings may have that effect. Nonetheless, in the court's view it is relevant that on the facts of this case, the question of "impairment" was never in play.

ix. the error in question is very time-limited: the criticism in issue was the appellant's failure to perform the tests on admission. There was no indefinite deferral of tests. Rather, the allegation focused on, and was confined to, what Dr. Ahmed was required to do on admission;

x. it was accepted by all the witnesses in the case that the circumstances in which B.K. was admitted were far from ideal. B.K. was referred as a haematology patient, and it was envisaged that he would be admitted in the afternoon. Instead, he was admitted to the hospital at 19:30 on the 6th of November - an after-hours admission. Therefore, many doctors senior to Dr. Ahmed had left the hospital;

xi. the appellant was a Registrar in Oncology serving as the on–call registrar for the evening. He was serving as a registrar for both the oncology and haematology departments. There was no evidence of any handover or specific direction having been given to him. Nor was there any evidence that he had been instructed to perform the tests in question.

xii. it was accepted by the CEO that it was not the role of the registrar to create a detailed management plan for the patient being admitted. Rather, when the patient was being admitted after hours, what was required was that the patient be managed until senior colleagues can do the review in the morning.

xiii. a critical matter of context was the fact that blood tests and renal function tests had been performed in the Bon Secours Hospital in Tralee on the afternoon of the 5th of November, and these tests were timed at 15:46. These tests were relied upon by both the appellant and by Dr. Fadalla.

xiv. Prof. McDermott accepted that it was reasonable for the appellant to prescribe analgesia in advance of obtaining new blood results, particularly by relying on the tests of the 5th of November 2012. When asked if he had any criticism of how the pain was managed, Prof. McDermott fairly stated that he had no criticism of how the pain was managed.

xv. Though the charge was broken in to 3 parts, it was accepted by the CEO that the case, properly considered, only involved one omission.

xvi. Dr. Fadalla felt he could carry out an assessment and change the dose of medication, even without up to date bloods or up to date kidney function tests. There is therefore something in defence counsel's point as to a contradiction within the CEO's case. This is not in any way a criticism of Dr. Fadalla who, after all, carefully wrote up the notes of his own examination and was landed in the situation of having to deal with

the patient without any examination notes to consult from the night before or up to date test results. But it does place a question mark over one element of the CEO's case concerning whether it was ill advised to prescribe morphine without refreshing the 5th November kidney function tests.

xvii. The CEO's case did not attach much significance to the failure to request a urine test. Nor was Prof. McDermott critical of the appellant not ordering a coagulation assessment in the circumstances.

xviii. Based on the facts here, some reasonable allowance should be made for "fog of battle" considerations. Hospital doctors work in hectic environments. Calls and decisions often fall to be made under pressurised conditions. The reason the appellant failed to write up the notes of his examination of patient B.K. was because he was called away to an over crowded A & E department to deal with an urgent matter in the case of another patient who was very unwell. As a result, he overlooked writing up the notes. In the circumstances, it may be harsh to exclude the possibility that the same pressures contributed to his error in not ordering fresh tests.

xix. Since a finding of PPP involves, in one sense, a declaration as to a doctor's *competence,* it is proper on the facts of this case to take some account of the overall passage of time since the events in question. The events the subject of the inquiry occurred in November 2012. The Fitness to Practice Inquiry took place in March and July 2015. From a proportionality perspective, since the case against the appellant involved a once-off error and did not involve an appraisal of a sample of the appellant's work, some allowance should be made for the historic nature of the charge and the overall passage of time.

149. To my mind, all of these factors, individually and collectively, mitigate the level of culpability and overall seriousness of the appellant's error. In the light of these points and

having regard to the overall circumstances of the case, I am not satisfied to the criminal standard that the suggested aggravating features push the appellant's once-off error across the required threshold of seriousness for a finding of PPP.

150. As referenced earlier in my judgment, I feel that a major factor that led to this matter developing into disciplinary proceedings *at all* was the way in which the appellant reacted and responded to the concerns initially raised by his colleagues. Instead of properly listening and heeding the complaints of his senior colleagues, and perhaps learning from the episode, the appellant became defensive and aggressive and refused to accept correction. All of this is clear from the evidence of Prof. Gupta, Dr. O'Keeffe and Dr. Fadalla. Their accounts in this regard were not contradicted by oral evidence from the appellant. In many respects, therefore, it could be said it was the appellant's own actions and initial response to his colleagues' concerns, that led to the matter blowing up into a disciplinary inquiry.

151. However, while that may be a relevant matter of context, the sole issue that is now before the court is the question whether the CEO has proved his case of poor professional performance to the required standard. For the reasons that I have sought to outline, I hold that the CEO's case falls short of the line. To borrow McKechnie J.'s phrase in *Corbally*, to find the appellant guilty on the facts here, *"would not reflect an appropriate balance between practice and protection"*. I am not satisfied that it has been proven that the appellant's conduct constitutes so serious a falling short of standards as to warrant a finding of PPP on his professional record. Accordingly, I hold that the appeal should be allowed and the finding of PPP, and the resultant sanction, should be quashed. I will hear submissions from the parties on the question of costs and on the terms of the order.

Appearances:

Lorna Lynch SC and Nathan Reilly BL instructed by Sheridan Quinn Solicitors for the appellant.

Tom Hogan SC and Nessa Bird BL instructed by Fieldfisher Solicitors for the respondents.

Signed: Mícheál P. O'Higgins