Privy Council Appeal No. 50 of 1994

Dr. Radhayshyam Ramdenee *Appellant*

v.

The General Medical Council *Respondent*

FROM

THE PROFESSIONAL CONDUCT COMMITTEE OF THE GENERAL MEDICAL COUNCIL

REASONS FOR REPORT OF THE LORDS OF THE JUDICIAL COMMITTEE OF THE PRIVY COUNCIL OF THE 17TH NOVEMBER 1994, DELIVERED THE 11TH JANUARY 1995

Present at the hearing:-

LORD MUSTILL
LORD LLOYD OF BERWICK
LORD NICHOLLS OF BIRKENHEAD

*[Delivered by **Lord Mustill**]*

This is an appeal from a direction of the Professional Conduct Committee of the General Medical Council on 26th July 1994 that the registration of the appellant should be suspended for a period of six months. At the conclusion of the hearing their Lordships agreed humbly to advise Her Majesty that the appeal ought to be dismissed. Their Lordships further directed that the ancillary application for leave to adduce further evidence should fall away and that the appellant should pay the respondent's costs. There now follow their Lordships' reasons.

Mr. Ronald Delves was admitted to Arrow Park Hospital, Wirral, on 12th March 1992. He was transferred to Royal Liverpool Hospital on 4th April 1992. Four days later he died, after a most distressing final illness involving amongst other features two amputations of limbs, and a caecal perforation. The cause of his death was a disease named Wegener's granulomatosis.

Dr. Radhayshyam Ramdenee was the general practitioner of Mr. Delves, and had made six domiciliary visits at the request of Mrs. Delves during the three weeks preceding his admission to hospital.

After the death of Mr. Delves proceedings were instituted by the General Medical Council against Dr. Ramdenee and on 26th July 1994 he appeared before the Professional Conduct Committee to answer a charge which, as amended, read as follows:-

"1. On the dates specified below you were responsible for the general medical care of Mr. Ronald Delves, a patient registered on your National Health Service list of patients;

2. (a) On 25 February and again on 4 March 1992 you made home visits to Mr. Delves;

(b) on the first of these two occasions you did not undertake a sufficiently thorough professional examination of Mr. Delves;

(c) on each of these two occasions you did not refer Mr. Delves for investigation and treatment of his condition by the hospital and specialist services, when his condition so required;

3. You did not make adequate entries in Mr. Delves' medical records concerning your treatment and management of his condition during February and March, 1992.

And that in relation to the facts alleged you have been guilty of serious professional misconduct."

There followed this exchange between Dr. Ramdenee's solicitor and the Deputy Chairman:-

" MR. PILLAY: Sir, on behalf of Dr. Ramdenee I indicate the following. He admits paragraphs 1, 2(a), 2(c) and new 3 of the charge.

THE DEPUTY CHAIRMAN: I formally announce that the Committee have found proved to their satisfaction charges 1, 2(a), 2(c) and new 3."

The Committee then proceeded to hear evidence from Mrs. Delves and Dr. Ramdenee, and addresses on behalf of the Council and the doctor. After deliberation the Committee found the facts alleged in paragraph 2(b) of the charge to have been proved, and after further submissions pronounced as follows:-

" THE DEPUTY CHAIRMAN: Dr. Ramdenee, the Committee take a serious view of the evidence which they have heard in this case both in relation to the shortcomings in your clinical management of this patient's care and the inadequacy of your record keeping concerning your treatment of his condition.

It is clear to the Committee that in both respects you failed to provide the patient with the competent and considerate professional attention which he had a right to expect of his general practitioner.

The Committee have judged you to have been guilty of serious professional misconduct in relation to the facts found proved against you in the charge and have directed the Registrar to suspend your registration for a period of six months."

Any person unacquainted with the course of these proceedings might well infer that Dr. Ramdenee, through the shortcomings to which the Deputy Chairman referred, bore a heavy responsibility for the death of Mr. Delves. Their Lordships must make it clear at the outset that such an impression would be entirely wrong. Wegener's granulomatosis is a rare disease, and one which is hard to diagnose. It was not until Mr. Delves had been in hospital for eight days that any member of the medical staff (a senior house officer in anaesthetics) first suggested that Wegener's disease might be at the root of his symptoms and a further eighteen days elapsed before, only three days before the patient's death, a firm diagnosis was made. In these circumstances it was not and could not have been suggested that a general practitioner ought to have diagnosed and identified Wegener's disease as the cause of the symptoms which, if Mrs. Delves was to be believed, were displayed by her husband on the two domiciliary visits covered by the charges. Nor was the possibility of a causal connection between Wegener's disease and those symptoms, or between the failure to refer the patient on the two occasions cited and his subsequent death, explored in any way at the hearing. The complaints concerning examination, referral and note-taking would have been just the same if Mr. Delves had made a full recovery.

It will have been observed from the exchange recorded above that the only contested issue of fact was whether there had been a sufficiently thorough examination on 25th February, and this is indeed what Miss Glynn, representing the Council, made clear to the Committee in her opening address.

This being so the underlying events may be very briefly described. Dr. Ramdenee first visited Mr. Delves on 18th February 1992. According to Mrs. Delves, her husband had been complaining of flu-like symptoms and painful knees. The doctor prescribed Voltarol for arthritis. By 24th February according to Mrs. Delves the symptoms had become more alarming, causing her to ring Dr. Ramdenee's locum, who suggested that the Voltarol should be discontinued. On the following day the doctor himself attended and after examining the patient prescribed antihistamine. Their Lordships will return to this visit in due course. At Mrs. Delves' request there

were further visits on 28th February, 2nd March and 11th March. The last home visit was on 12th March. The patient's condition had plainly deteriorated. According to the doctor he found purplish discolouration of the left big toe and diminution of the pulse in the leg. In consequence he arranged for Mr. Delves to be admitted to Arrow Park Hospital.

Returning to the evidence before the Committee concerning the home visit of 25th February it was common ground that -

1. On 24th February Mrs. Delves reported to the locum or the practice nurse that her husband had marks on his legs; there was a lump on his forehead; his gums were black and swollen and there was a foul smell. She also reported that he was bleeding from the rectum.

2. This report was passed on to Dr. Ramdenee and was the reason for his visit on 25th February.

3. The doctor did examine the patient's mouth and legs.

4. Whatever rectal bleeding there had been on 24th February had stopped by the following day. There was no record of any recurrence in the practitioner's or hospital's clinical records.

5. There is no mention in the patient's medical records either of what Dr. Ramdenee found or did not find on 25th February or of the symptoms recounted to him. Indeed there is virtually nothing useful in his records for any relevant date.

On the matters which remained in contention, Dr. Ramdenee's evidence was that he performed a rectal examination and found nothing; Mrs. Delves denied that he performed any such examination. As to the other symptoms Mrs. Delves' evidence was rather unfocussed. In particular it is not clear whether she was saying that they were still present on 25th February, as distinct from the previous day; although she did testify, as regards the marks on the legs which were more prominent than before, that she "remembered making the point". Dr. Ramdenee's evidence was that he did not find any of the symptoms described and said as much to Mrs. Delves. He did examine the legs; took pulses; and saw no marks.

As to the visit on 4th March, which was the subject of the admitted charge 2(c), Mrs. Delves telephoned the surgery on the previous day to report that her husband's condition was worse and that she wanted blood tests to be taken. Dr. Ramdenee called whilst Mrs. Delves was out and was admitted by her sons. He took blood samples and left a message that she was to ring for the results on the following Monday, 9th March.

Leaving aside the question of penalty, the Committee had four tasks. First, to decide whether Mrs. Delves or Dr. Ramdenee was telling the truth about the rectal examination. Second, to decide what symptoms had been reported to and found by Dr. Ramdenee on 25th February. Third, to consider, in the light of what they found the doctor had seen and heard on 25th February and 4th March, how grave was his admitted fault in failing to refer the patient for investigation. Fourth, in the light of all the symptoms seen and reported, how grave was his failure to keep proper medical records. Distinct findings on these issues were not made, but it is obvious that the Committee did not believe Dr. Ramdenee where his evidence differed from that of Mrs. Delves, and took a serious view of his failure to act on and record whatever he had seen and been told.

In this state of affairs an appeal, absent the special features referred to below, would have been hopeless. The Committee saw the witnesses, the Board has not. It was the task of the Committee, not the Board, to make up its mind on what happened, what did not happen and what should have happened. Having made its own assessment of the course of events it was for the Committee to decide on the penalty. The Board was reminded of the history of the words "serious professional misconduct", of which the Committee and its advisers cannot have been unaware. The penalty imposed on Dr. Ramdenee may seem severe, but it is quite impossible to hold, when the penalty is measured against the facts as the Committee must have found them, that it was either "irrational" in the well-known legal sense or displayed some misunderstanding of the standard to be applied. Their Lordships pause only to note that *Felix v. The General Medical Council* [1960] A.C. 704, which was relied on to show that failure to keep proper records cannot amount to what is now serious professional misconduct, establishes no such rule. The complaint there was that the practitioner, through a combination of carelessness and failure to supervise an employee, had charged the National Health Service for work which had not been done. Such an error of book-keeping, serious though it may be, is far distant from the absence of clinical records: for the information about the development of the complaint given by proper records may be of critical importance to those into whose care the patient may later be transferred. In any event, however, it is plain that the penalty imposed by the Committee was not based on record-keeping alone.

If this were the whole of the appeal the decision of the Board would be inevitable and could be expressed in a very few lines. Their Lordships have set out the history at some length only by way of introduction to the new case presented on appeal. Dr. Ramdenee has changed his legal representation, with the result that the Board has been invited to consider an entirely new proposition of fact.

The thrust of the argument is this. What must have struck the Committee most forcibly, in relation to the visits of 25th February and 4th March, was the apparent failure of Dr. Ramdenee to find and react to the patient's striking and worsening symptoms. The new case is that this happened because there was nothing to find. It is a characteristic of Wegener's disease that the symptoms are evanescent. Mrs. Delves could still be believed (and the Committee must have believed her) whilst leaving the practitioner free from blame.

This case was presented with skill by Mr. Engelman. In support there was tendered a very recent draft statement by Dr. J.M.I. Iveson, a consultant rheumatologist of much experience, which the Board was invited to accept as fresh evidence.

As may often happen in cases where there is an application to call fresh evidence the Board was compelled to find out the contents of the statement before deciding whether to admit it. It was found to consist in part of a description of Wegener's disease; in part of an analysis of the hospital records; and in part of an account (from what source is not clear) of what Dr. Ramdenee claimed to have said and done. Much of the statement would have been highly relevant if the complaint had been that a better examination would or might have prevented Mr. Delves' death. As already pointed out no such charge was ever made. The remainder of the statement was however germane to the new case, and their Lordships therefore made a provisional examination of it, notwithstanding the obvious (and usually insuperable) objection that there was no reason why it should not have been adduced before the Committee. In the event their Lordships found nothing of substance in it beyond what Mr. Engelman was able to demonstrate from the hospital records. In practice therefore the admissibility of the statement as fresh evidence stood or fell with the admissibility of the new case as a whole, and their Lordships need not enter into the procedural difficulties which might otherwise have arisen.

In their Lordships' opinion this new case should not be admitted, for three broad reasons. First because it does not bear on what the Committee plainly regarded as the central issue of fact, whether Dr. Ramdenee performed a rectal examination on 25th February. Secondly, because it would require consideration of the question, scarcely touched on in cross-examination, of whether symptoms reported before 25th February and 4th March were still present when the domiciliary calls were made. Finally, and perhaps most significantly, the practitioner was in a dilemma. Either the symptoms were there and he missed them, or they had abruptly disappeared and he should both have realised the strangeness of their disappearance and referred the patient for tests, and made clinical records which would have been of value to those who had later to assess the patient's puzzling complaint. Those conducting

the case for the Council were plainly alive to this dilemma. After a question to Dr. Ramdenee in cross-examination about whether he said that Mrs. Delves was lying (to which exception was rightly taken), their Lordships find the following exchange:-

"Q. In relation to what you had been told by the receptionist, do you agree that there are two alternatives? Either Mrs. Delves is lying or the symptoms had cleared up on your evidence.

A. I cannot say.

MISS GLYNN: Which did you think it was?

MR. PILLAY: It has never been suggested that Mrs. Delves was lying. There might be a number of other explanations. To put it in that stark way is unfair to the witness and indeed to the respondent.

Q. MISS GLYNN: What did you think the position was on the 25th, given that you had been given that information by the receptionist?

A. I have said that those symptoms were not present.

Q. Why did you think they were not present?

A. Maybe they did not exist at all.

Q. On your evidence, was not another alternative that they had existed but had cleared up for some reason?

A. That could be so, but it is an assumption.

Q. If they had cleared up would you have thought it appropriate to take blood tests to find out what had happened during the preceding 48 hours?

A. I do not think so. When a blood test is indicated one has to go, according to the patient's condition, and deal with it. My view on that particular day was that it was not indicated.

Q. You did not feel that it was necessary to take blood tests because as far as you were concerned there had never been any of the problems described by your receptionist. Is that right?

A. I did not say they had never existed. I said that I did not find them.

Q. We may be at cross-purposes. Because you did not find them when deciding on the course of action you should take did you think (a) that there never

had been such symptoms and therefore you need not worry about them, or (b) that there had been symptoms and therefore you had to do something?

A. As I have already answered, my evaluation of the situation on that particular day was that there was no indication for a blood test there and then."

If there then had been any suggestion on Dr. Ramdenee's behalf that the symptoms were truly reported but had disappeared, the enquiry would plainly have taken a different turn, very possibly with results just as unfavourable to Dr. Ramdenee as those which ensued by the more direct route.

In these circumstances their Lordships cannot find that the very high requirements are satisfied which would justify an order calling for the entire procedure to be started again on a basis which could have been but was not pursued at the time.