Neutral Citation Number: [2013] IEHC 500

THE HIGH COURT

JUDICIAL REVIEW

[2012 No. 1028 JR]

BETWEEN

MARTIN CORBALLY

APPLICANT

AND

THE MEDICAL COUNCIL, IRELAND AND THE ATTORNEY GENERAL

RESPONDENTS

AND

THE HUMAN RIGHTS COMMISSION

NOTICE PARTY

JUDGMENT of Kearns P. delivered on the 14h day of November, 2013.

The applicant is a professor of medicine and a consultant paediatric surgeon who was working in Crumlin Children's Hospital in 2012 but who is now working in Bahrain. The application is brought by way of judicial review to quash the decision of the first named respondent made on the 26th October, 2012, whereby the sanction of admonishment was imposed on the applicant in relation to his professional performance in the context of a frenulum release procedure carried out in Our Lady's Children's Hospital, Crumlin, on the 30th April, 2010. The applicant also seeks an order of certiorari quashing the finding of the first named respondent's Fitness to Practise Committee (hereinafter "FPC") set out in its report dated the 6th October, 2012, and notified to the applicant by letter dated the 26th October, 2012, whereby the FPC purported to make three findings of poor professional performance on the part of the applicant.

Other claims for relief are detailed in the statement grounding the application for judicial review, including, in particular, claims that Part 8 of the Medical Practitioners Act 2007, insofar as it fails to provide the applicant with an appeal from the first named respondent's decision and/or the FPC findings, breaches certain constitutional rights of the applicant and is for that reason unconstitutional. A declaration is also sought pursuant to s. 5 of the European Convention on Human Rights Act 2003 that Part 8 of the Medical Practitioners Act 2007, insofar as it fails to provide the applicant with an appeal from the first named respondent's decision and/or the FPC findings is incompatible with the State's obligations pursuant to Article 6 (1) of the Convention itself.

By agreement between the parties, these claims of unconstitutionality and failure to comply with the requirements of the Convention were not proceeded with, pending resolution by this Court of the matters first outlined above.

THE FACTS

In early 2010, patient X, then two and a half years of age, was referred to the applicant's private clinic in Our Lady's Children's Hospital in Crumlin by her G.P. with a history that the frenulum under her top lip was catching, causing an ulcer under that lip and contributing to a gap in her front teeth.

There are three frenula (congenital folds of tissue) in the mouth: an upper frenulum (a fold of tissue between the inner aspect of the upper lip and the anterior gum margin), a lower frenulum (between the lower lip and the anterior lower gum margin) and a tongue or lingual frenulum (under the anterior surface of the tongue). All three are small folds of tissue found in the midline.

Having examined patient X on the 25th February, 2010, the applicant recommended division of her upper frenulum, a straightforward and minor surgical procedure which normally takes less than one minute to complete. In writing up his notes of the examination, the applicant, who had correctly diagnosed patient X's condition, described the required procedure as excision of "upper lingual frenulum". There is no upper lingual frenulum and it is perhaps more accurately described as an 'upper labial frenulum'.

On the 11th March, 2010, the applicant booked the patient in for her procedure and correctly completed an admissions form for the patient, listing her for a "tongue tie (upper frenulum)". The procedure was to be performed as a day case on the 30th April, 2010. This form was sent to the admissions department where the patient's details and the proposed procedure were entered into the patient administration system. Unfortunately the reference to the upper frenulum, through no fault of the applicant, was not inputted into the hospital system.

Difficult as it is to believe, the system as it then operated in Crumlin had one code only for all frenula dissection – all three types being described as "tongue tie". That being so the operation was inputted in the system as "tongue tie release" without the addition of the words "upper frenulum".

Following her admission on the 30th April, 2010, the patient's family provided and furnished a consent to the procedure to the applicant's senior house officer, Dr. A.J. Orafi, for a "tongue tie – upper frenulum release". It is interesting to note that in the account of the consent process furnished by the mother of patient X, she maintains that when the doctor started to describe her daughter's case as a "tongue tie procedure" she corrected the doctor by saying that it was her upper lip that needed a release and not her tongue. The junior doctor apparently stated that the procedure would still be called tongue tie. However, on the consent form also the procedure was clearly described as "tongue tie (upper frenulum) release". It is worth noting that this pre-operative conversation took place in the presence of one of the nursing staff, Nurse Pollard, but it appears that this particular detail, for whatever reason, was not passed on to the surgical team in accordance with the "Correct Site Surgery Policy".

While the applicant had intended to perform the surgery himself, he was called as a matter of urgency to attend to another patient in the intensive care unit. His account of events makes clear he was working under considerable pressure at the time. His specialist registrar, Dr. Farhan Tareen was thus delegated by him to perform the procedure. There is no issue but that the procedure was well within Dr. Tareen's capability.

On the occasion in question the applicant accepts that he asked Dr. Tareen in the hospital corridor what was happening with the theatre list, reviewed it and asked Dr. Tareen to perform the tongue tie. The applicant asserted that he delegated the procedure by referring to the description on the theatre list. The hospital at the time had a protocol for a "surgical pause/time out" procedure in advance of the commencement of surgery. Both Dr. Tareen, the anaesthetist and nursing staff were present at the surgical pause. The purpose of the surgical pause is to undertake and complete a check to ensure that the correct patient is listed for the correct procedure at the correct site.

No evidence was given to the inquiry before the FPC that anyone during the surgical pause ever looked at the applicant's notes. However, confusing as the original entry might have been, any confusion, had it arisen for that reason, would have been quickly eliminated by reference to the consent form, the admissions card, or to the pre-operative discussion between the parents of patient X and the SHO and/or Nurse Pollard, wherein the patient's mother drew express attention to the site of difficulty.

Unfortunately, Dr. Tareen, in respect of whom charges were not pursued at the hearing before the FPC, carried out a lingual frenulectomy, which was an unnecessary procedure and one which, having been carried out, left the patient still requiring the upper frenulum release which was undertaken when the child was brought back to theatre that same day.

It is perhaps important to stress that this second procedure was uneventful and the child made a full recovery after a short period of pain and discomfort from the lingual frenulectomy and is suffering no ongoing disability as a result of the unnecessary operation which was performed.

Nevertheless, her parents were understandably upset and annoyed that the particular incident occurred and lodged a complaint with the first named respondent on the 4th September, 2010, alleging poor professional performance against Professor Corbally and his colleague Dr. Tareen.

From the outset, the applicant admitted that his wording of the procedure in his original notes was inaccurate and made a full and comprehensive apology to the parents of patient X. In fairness, everyone involved in what had occurred quickly realised that a series of errors and poor communication had brought about the particular mishap which at least had the fortunate consequence that a completely new protocol for such procedures was devised and put into place at the hospital so as to ensure that no such confusion or mistake could ever again occur.

Following receipt of the complaint the Preliminary Proceedings Committee of the Medical Council formed the opinion that there was a *prima facie* case to warrant further action being taken in relation to the complaint and referred same to the FPC. The FPC decided to hold an inquiry at which some eight allegations of poor professional performance were advanced. At the hearing, the majority of these allegations were withdrawn, but nonetheless the FPC made three specific findings against the applicant as follows:-

> "**Allegation number 1**:
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> That on or around 25th February, 2010 Mr. Corbally incorrectly described the procedure required for patient X in her medical records as excision of 'upper lingual frenulum'.
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> Having regard to the evidence adduced, the Committee found that:
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> Allegation 1 was proven as to fact.
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> Reason:
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> The Committee is satisfied, beyond reasonable doubt, on the basis of Prof. Corbally's admission and the documentary evidence adduced that the facts are proven.
>
> Allegation 1 did amount to poor professional performance.
>
> By a majority the Committee is satisfied beyond reasonable doubt that this constitutes poor professional performance, on the basis of the expert evidence given by Mr. Grant and notwithstanding the expert evidence to the contrary given by Mr. O'Driscoll. The wrong diagnosis was recorded in circumstances where Prof. Corbally had a responsibility to accurately document the problem and planned surgical procedure. A minority view is that this entry did not influence the booked hospital procedure and therefore did not constitute poor professional performance.
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> **Allegation number 6**:
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> That on or around 30th April, 2010, Mr. Corbally delegated patient X's surgery to Dr. Fahran Khaliq Tareen ("Dr. Tareen") in circumstances where he failed to communicate adequately or at all to Dr. Tareen the procedure to be performed on patient X.
>
> Allegation 6 was proven as to fact.
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> Reason:
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> The Committee is satisfied, beyond reasonable doubt, on the basis of Prof. Corbally's admission and the corroborative evidence adduced that the facts are proven.
>
> Allegation 6 did amount to poor professional performance.
>
> The Committee is satisfied, beyond reasonable doubt, that this constitutes poor professional performance, on the basis of the expert evidence given by Mr. Grant and notwithstanding the expert evidence to the contrary given by Mr. O'Driscoll. Both expert witnesses agreed that Prof. Corbally was entitled to delegate this procedure to a qualified colleague; however Mr. Grant's view convinced the Committee that he also had a responsibility to issue the correct instruction when making

the delegation. This responsibility exists notwithstanding the pressures of work set out by Prof. Corbally. The known weaknesses in surgical systems at the hospital, such as the absence of team briefings before surgery commences and the absence from theatre (on occasion) of the doctor who has consented the patient/parents, only serve to increase the responsibility on a senior surgeon to communicate adequately when delegating a procedure to a junior.

Allegation number 8:

That Mr. Corbally failed to apply the appropriate standards of clinical judgment that could be expected from a surgeon with your experience or expertise.

Allegation 8 was proven as to fact.

The Committee is satisfied, beyond reasonable doubt, on the basis of the expert evidence given by Mr. Grant and notwithstanding the expert evidence to the contrary given by Mr. O'Driscoll that the facts are proven.

Allegation 8 did amount to poor professional performance.

The Committee is satisfied, beyond reasonable doubt, that this constitutes poor professional performance, on the basis of the expert evidence given by Mr. Grant and notwithstanding the expert evidence to the contrary given by Mr. O'Driscoll. The Committee had regard in particular, to the evidence that this procedure was rarely carried out in OLHC and that the surgical booking/coding system was known to be incapable of coding a procedure such as division of upper lip frenulum. In these circumstances, Prof. Corbally had a particular responsibility to ensure that all necessary precautions were taken to ensure that the patient received the correct surgery. His failure to do so, by relying on systems known or suspected to be flawed, constitutes poor clinical judgment."

The FPC considered in addition that it was appropriate to specify that the hearing had thrown up significant evidence of systems failures at the hospital and recommended that the Medical Council pursue them. This concern focussed specifically on inadequate surgical booking/coding systems, the lack of implementation of the hospitals own "correct site surgery" policy and failure to effectively implement the surgical pause procedure, coupled with weaknesses in communication and leadership.

The FPC then concluded its report by recommending to the Council that it impose the sanction of admonishment or censure on the applicant, offering the following reason for doing so:

> *"The three findings of poor professional performance reflect a falling below the standards expected of a consultant paediatric surgeon. A sanction is appropriate in these circumstances and the Inquiry team believes admonishment or censure is proportionate to the content of the findings."*

The Council considered the report from the FPC and decided, under the provisions of s. 71 (a) of the Medical Practitioners Act 2007, as amended, to admonish the applicant in relation to his professional performance.

While this is the least serious of the sanctions provided for by s. 71 (a) of the Act, it nonetheless represents a serious sanction from the applicant's point of view, not least because the decision would, absent the present proceedings, be notified to the public and to the registration authority in Bahrain where the applicant is currently working. The gravity of the matter from the perspective of the applicant could hardly be greater because he was the subject of extensive media coverage in relation to this case, which, had it been a trial before judge and jury, would most certainly have caused the trial to be aborted. The media reports stressed and emphasised that there had been a prior inquiry into the applicant's conduct in a case which involved the removal of the wrong kidney from a six year old boy at the same hospital in 2008. That was also a case where the applicant had delegated the operation to a surgical registrar. That particular inquiry was halted as the Medical Council decided that the applicant and another medical colleague did not have a case to answer, although both the applicant and his colleague gave certain undertakings to the respondents at that time in relation to their future conduct. There was no suggestion (that the Court is aware of) and no finding by the FPC that the 2008 incident resulted from an erroneous note prepared by the applicant. While counsel on both sides say that the FPC had no regard to the prior incident, the nature and extent of the publicity surrounding the hearing were highly prejudicial to the applicant in terms of his career. That said, the absence of any adverse finding against the applicant from the 2010 inquiry or any other inquiry put this case in quite a different category than if there had been a prior finding of misconduct or poor professional performance made against him.

THE MEDICAL PRACTITIONERS ACT 2007

All steps taken in this matter were taken by the respondents pursuant to the provisions of the Medical Practitioners Act 2007.

The broad purposes of the Act appear in the long title which states as follows:-

> *"An Act for the purpose of better protecting and informing the public in its dealings with medical practitioners and, for that purpose, to introduce measures, in addition to measures providing for the registration and control of medical practitioners, to better ensure the education, training and competence of medical practitioners, to amend the membership and functions of the Medical Council, to investigate complaints against medical practitioners and to increase the public accountability of the Medical Council; to give further effect to Council Directive 2005/36/EC; and, for that purpose, to repeal and replace the Medical Practitioners Acts 1978 to 2002 and to provide for related matters."*

> *"[P]oor professional performance" is defined in s. 2 of the 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."*

Part 8 relates to complaints referred to the Fitness to Practise Committee and contains sections relating to the hearing of complaints by the Fitness to Practise Committee, including the conduct of a hearing and providing for a report to be made to the first named respondent by the Fitness to Practise Committee.

Section 69 of the Act provides:-

> *"(1) Subject to subsection (2), the Fitness to Practise Committee shall, on completing an inquiry into a complaint,*

submit to the Council a report in writing on its findings.

(2) The report referred to in subsection (1) of the Fitness to Practise Committee—

(a) shall specify—

(i) the nature of the complaint that resulted in the inquiry,

(ii) the evidence presented to the Committee, and

(iii) the Committee's findings as to whether any allegation is proved,

and

(b) may include such other matters relating to the registered medical practitioner the subject of the complaint as the Committee considers appropriate."

Thereafter, s. 70 as amended by s.12 of the Medical Practitioners (Amendment) Act 2011 provides:-

"The Council shall, on receiving the report referred to in section 69 (1) of the Fitness to Practise Committee in relation to a complaint—

(a) if the Committee finds that no allegation against the registered medical practitioner the subject of the complaint is proved, dismiss the complaint,

(b) if the Committee finds that any allegation against the practitioner is proved, decide [under section 71 or 71A, as may be appropriate] one or more than one sanction to be imposed on the practitioner."

Part 9 of the Act then deals with the imposition of sanctions on registered medical practitioners following reports of Fitness to Practise Committee.

Section 71 of the Act provides as follows:-

"71.— Subject to sections 57 (6)(a) and 72 , the Council shall, as soon as is practicable after receiving and considering the report referred to in section 69 (1) of the Fitness to Practise Committee in relation to a complaint concerning a registered medical practitioner where section 70 (b) is applicable, decide that one or more than one of the following sanctions be imposed on the practitioner:

(a) an advice or admonishment, or a censure, in writing;

(b) a censure in writing and a fine not exceeding €5,000;

(c) the attachment of conditions to the practitioner's registration, including restrictions on the practice of medicine that may be engaged in by the practitioner;

(d) the transfer of the practitioner's registration to another division of the register;

(e) the suspension of the practitioner's registration for a specified period;

(f) the cancellation of the practitioner's registration;

(g) a prohibition from applying for a specified period for the restoration of the practitioner's registration."

Section 74 of the Act of 2007 as amended by s.17 of the Medical Practitioners (Amendment) Act 2011 provides:-

"A decision [under section 71 or 71A] to impose a sanction (other than a sanction referred to in [section 71 (a) or 71A(a)]) on a registered medical practitioner shall not take effect unless the decision is confirmed by the Court on an application under section 75 or 76."

A right of appeal is available to a registered medical practitioner who is the subject of a decision under s. 71 to impose a sanction, but not where the sanction is a sanction referred to in s. 71 (a).

THE APPLICANT'S CASE

It is first submitted on behalf of the applicant that the admitted error in this case did not and could not come within the definition of "poor professional performance" as set out in s. 2 of the Act. It was submitted that the definition refers to a failure by the practitioner to meet the standards of competence which can reasonably be expected of medical practitioners practising medicine of the kind practised by the applicant. The definition therefore clearly relates to standards of competence and not, as in this case, a simple error in writing up medical notes. In assessing whether a professional person is competent, regard ought to be had to their overall abilities and powers and there had been no suggestion before the first named respondent that the applicant was other than a highly capable and competent practitioner. It was submitted that the concept of "poor professional performance" envisages a continuum of behaviour, a persistent or ongoing failure by a practitioner in the knowledge and skill or the application of knowledge and skill. A once-off "typographical error" could not be said to call a practitioner's competence into question. Given that a finding inexorably leads to a sanction, it was submitted that not every error could be capable of constituting poor professional performance; this could only arise where the failing is such as to warrant a concern over the competence of the medical practitioner.

While "poor professional performance" had not been the subject matter of statutory or judicial definition in this jurisdiction, it was submitted that the terms 'poor' and 'deficient' were interchangeable and that the court could and should have regard to the interpretation of the latter term in the United Kingdom, most importantly in *R (on the application of Calhaem) v. The General Medical Council* [2007] EWHC 2606 (Admin), in which Jackson J. had noted that a single act or omission could only constitute deficient practice if it was "very serious indeed".

Reliance was also placed on the case of *Krippendorf v. General Medical Council* [2001] 1 W.L.R. 1054, a decision of the Privy Council which was one which, as in this case, was more concerned with deficient performance than misconduct. The court in that case had defined "seriously deficient performance" at p.1056 as:-

> *"…'[A] departure from good professional practice, whether or not it is covered by a specific GMC guidance, sufficiently serious to call into question a doctor's registration.' This means that we will question your registration if we believe that you are repeatedly or persistently, not meeting the professional standards appropriate to the work you have been doing – especially if you might be putting patients at risk."*

It was submitted that a practitioner's entire performance should be considered in the context of a complaint of poor professional performance. The FPC had before it testimonials from patients, medical practitioners and nursing staff in respect of the applicant's abilities. The applicant had also taken part in a feedback analysis organised by the first named respondent in which he had been assessed by peers and patients, and in which his diagnostic skills were assessed as outstanding. Further, virtually all of the participants characterised his performance of practical and technical procedures as outstanding. Evidence to that effect had been given to the hearing by Dr. O'Sullivan, Consultant Paediatric Pathologist at the same hospital, who had worked with the applicant over a five year period and who described the applicant as "an excellent surgeon with extraordinary skills, an exceptional communicator and gifted teacher with a passion for teaching.".

It was further submitted on behalf of the applicant that there must be some threshold established before a finding of poor professional performance is made, given that a sanction must inexorably follow. It was appropriate therefore for the court to imply the term "serious" when assessing the alleged poor professional performance, and this was the course which had been adopted by Keane J. in *O'Laoire v. The Medical Council* (Unreported, High Court, Keane J., 27th January, 1995).

It was particularly difficult to support such a conclusion where, as in this case, the admitted error was not causative of the later damage, in the sense that numerous opportunities had arisen whereby the confusing entry in the notes could have been detected and corrected. This could and should have been picked up by reference to the admission form which was completed for the purpose of internally scheduling this plaintiff for the surgical procedure. The coding system for the patient administration system and the theatre management system in operation at the hospital did not differentiate between the three procedures, but had only one term for all frenula dissection, namely, "tongue tie". The applicant had included the text "upper frenulum" in the admissions form to clarify which procedure was to be performed on the patient and while the administration system allowed for the insertion of free text, this information had not been inputted into the system. It had been accepted at the hearing that the error to include the clarifying addition had been made by some unknown administrator. Further, the patient's mother had clarified with two members of staff that her child's upper lip needed release, and not her tongue. She had informed both the senior house officer and Nurse Pollard of this fact. The consent form which was completed by the senior house officer also correctly clarified the procedure and this document was available prior to the commencement of the surgery. While a surgical pause in accordance with hospital policy had been performed, it appeared that the consent form had not been looked at. The applicant had delegated to a well qualified delegate because he had to deal with a patient who was critically ill and who had undergone emergency surgery some days earlier.

In all the circumstances, the particular error in this case could not reasonably or rationally be said to reflect on the competence of the doctor. It certainly did not reflect upon his knowledge or skill.

It followed therefore that there had been an erroneous interpretation in law by the respondents as to the exact meaning of the term "poor professional performance".

Alternatively, it was submitted that the findings and sanction imposed on the applicant were irrational and disproportionate findings having regard to the gravity of the case from the applicant's point of view and the absence of any right of appeal. It was submitted that in *Meadows v. Minister for Justice Equality and Law Reform* [2010] 2 I.R. 701 the Supreme Court had clarified that in judicial review proceedings, especially where constitutional rights are at issue, an administrative decision may be challenged on the grounds that it is disproportionate. Such a challenge was particularly appropriate in this case, having regard to the fact that no right of appeal was open to the applicant having regard to the sanction which had been applied under s. 71 (a) of the Act. In *Efe (a minor) & Ors. V. Minister for Justice, Equality and Law Reform & Ors.*, [2011] 2 I.R. 798, the High Court (Hogan J.) had held that in fundamental rights cases a rule of law which purported to constrain a court from protecting rights on the basis that it could only interfere where there was "no evidence" to justify a factual conclusion would be at odds with the Constitution. In that case Hogan J. had held that *Meadows* had reinterpreted the test in *O'Keeffe v. An Bord Pleanála* [1993] 1 I.R. 39 by emphasising and focusing on proportionality. He held that, post *Meadows*, it was no longer correct to say that the courts are constrained to apply an artificially restricted test for review of administrative decisions affecting a fundamental rights and reasonableness and rationality grounds. Rather, the test is now broad enough to ensure that the substance and essence of constitutional rights will always be protected against unfair attack if necessary through the application of a proportionality analysis.

In *Prendiville v. Medical Council* [2008] 3 I.R. 122, Kelly J. had noted that "[a] finding of professional misconduct against any professional person is very serious" (para. 56). Clear evidence had been given in this case by Mr. O'Driscoll, consultant ENT specialist, of his view that the applicant had not engaged in poor professional performance. Mr. Grant, the expert engaged by the Chief Executive Officer, working as he was in the United Kingdom, was not in a comparable position to the applicant, a proposition which Mr. Grant himself accepted. Mr. Grant was not familiar with practices in Ireland and, it was submitted, had given varying and inconsistent opinions on what constituted poor professional performance.

Insofar as the FPC had made a finding against the applicant in respect of allegation number 8, it was further submitted that such a finding offended the principle of proportionality given that the finding in question had already been the subject of the findings made in respect of allegations number 1 and 6.

It was also submitted that the FPC had failed to provide intelligible, adequate and informative reasons for the particular findings which it did make. Both sides had requested that such reasons be given, as had the legal assessor to the FPC. While of course the FPC had set out some reasons, they had not addressed the question as to why the FPC preferred the evidence of Mr. Grant to that of Mr. O'Driscoll. More crucially, they had failed to give reasons as to how the facts as found fitted within the legal concept of "poor professional performance".

In addition, reliance was placed upon fair procedures points, by reference to which it was contended that the applicant was at fault in this case because he knew of weaknesses in the system within the hospital, but it had been no part of the CEO's original case against the applicant. The FPC had apparently placed reliance upon Mr. Grant's evidence to the effect that the error in the theatre list was the fault of the applicant whereas in fact it had not been his fault. To trail in an additional basis of complaint which had not been alleged against the applicant, was, it was submitted, manifestly unfair. Equally, the superfluous additional finding made under

allegation number 8 was also a breach of fair procedures, given that findings made in respect of other allegations rendered any finding under allegation number 8 superfluous. Yet that finding had clearly gone "into the mix" in determining the findings and sanction arrived at in this case.

THE RESPONDENTS' CASE
On behalf of the respondents it was submitted that this was a simple case, brought in this way only because there was no right of appeal.

In reality there was only a single legal issue in this case, namely, what constitutes "poor professional performance"?

The answer was to be found in the definition of poor professional performance set out in the Act. That definition does not require any threshold of high seriousness nor does it require that a continuum of behaviour or conduct be established.

It could not be denied but that the applicant had made an error in describing the patient's condition as one of "upper lingual frenulum" and this had appeared in the patient's chart. The fact that others may also have been at fault in this case could not exonerate the applicant.

In the instant case the FPC had evidence to support its findings and was entitled to prefer the evidence of Dr. Grant to that of Dr. O'Sullivan. Extremely detailed submissions had been made to the FPC as to why they should not make findings against the applicant. The FPC heard those submissions, considered them, and rejected them, as they were entitled to do. The FPC had imposed a minor sanction which was adopted by the first respondent. The sanction imposed was entirely proportionate in the circumstances of the case.

It could not be said, in relation to poor professional performance, that a single error could never constitute poor professional performance. It would be quite absurd to contend that the respondents should wait for a series of events to occur before they could act.

The English authorities relied upon by the applicant arose from a very different statutory framework. The earlier Irish statutory scheme set forth in the Medical Practitioners Act 1978, provided for the holding of inquiries into "professional misconduct" or a practitioner's "fitness to engage in the practise of medicine by reason of physical or mental disability".

The meaning of professional conduct was thus originally limited to conduct which was disgraceful in the professional respect, and was gradually extended to encompass what might be described as "seriously deficient performance" by a medical practitioner. This change was effected in Ireland by the decision in *O'Laoire v. The Medical Council* (Unreported, Keane J., 27th January, 1995).

Under the Act of 1978, it was necessary (in order for there to be a finding of professional misconduct), for the registrar to present evidence of conduct in which the medical practitioner has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners. For example, conduct which could give rise to a successful action in negligence would not, of itself, give rise to a finding of professional misconduct. Further, it has always been the case that a single act or omission can give rise to a finding of professional misconduct.

The Act of 2007 introduced a new system of professional regulation whereby the Oireachtas greatly widened the matters in respect of which a complaint could be made. In particular, the Oireachtas introduced the concept of poor professional performance, which is clearly intended to refer to conduct which does not amount to professional misconduct.

In this case, the applicant's advisors had ignored the express definition contained in the Act and had relied instead on English case law as to the meaning of "seriously deficient performance". It was submitted that the English authorities were not particularly helpful. The Medical Act 1983 does not use the phrase "poor professional performance". Insofar as it does refer to performance, the English authorities use the phrases "seriously deficient performance", "grossly deficient performance", and "deficient performance", all without any statutory definition.

What had occurred in England was that the Committee on Professional Performance had indicated an interpretation of "seriously deficient performance" in a booklet published in November 1997 as follows:-

> "Seriously deficient performance is a new idea. We have to find it as 'a departure from good professional practice, whether or not it is covered by specific GMC guidance, sufficiently serious to call into question a doctor's registration'. This means that we will question your registration if we believe that you are, repeatedly or persistently, not meeting the professional standards appropriate to the work you are doing – especially if you might be putting patients at risk."

If the applicant's submission was correct, it would effectively mean that professional misconduct and poor professional performance were one and the same thing. This proposition derives from the statement in *Calhaem* at para. 39 that a:-

> *"Single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute 'deficient professional performance'."*

Accordingly, if the applicant is correct, a single act could only ever be poor professional performance if it was "a very serious" failure by the practitioner to meet the standards of competence reasonably to be expected of medical practitioners practising medicine of the kind practised by the practitioner. If such a word is implied into s. 2 of the Act of 2007, it is hard to see the difference between professional misconduct and poor professional performance. As the Oireachtas must be presumed to have intended an amendment to the law to differentiate between "professional misconduct" and "poor professional performance" the word "serious" cannot be implied into the statutory scheme as the applicant contends.

In relation to the applicant's second submission, it was contended on behalf of the respondents that the sanction of admonishment could not be said to be fundamentally at variance with reason or commonsense. Nor could they be said to be unsupported by any relevant material. Both the FPC and the Council had ample material before them on the basis of the evidence to support the finding and sanction imposed. The finding and sanction were not disproportionate.

In *Meadows v. Minister for Justice Equality and Law Reform* [2010] 2 I.R. 701, the majority of the Supreme Court held that the test of reasonableness in the context of judicial review proceedings encompasses the notion of proportionality. In other words, when reviewing administrative decision-making in the context of judicial review, a court is required to assess the proportionality of the impact of that decision on the constitutional rights of the affected person. In a case where the sanction of admonishment only was

imposed, it is difficult to argue that proportionality can be an issue at all. Further, the majority of the court in *Meadows* determined that the test of reasonableness which has been applied since *The State (Keegan) v. Stardust Victims Compensation Tribunal* [1986] I.R. 642 was adequate to provide an effective remedy in judicial review, even where the decision under review has the potential to affect a person's fundamental rights.

Finally, in the context of proportionality, the Court was reminded that in *McManus v. Medical Council* [2012] IEHC 350 (Unreported, High Court, Kearns P., 14th August, 2012), this Court was obliged to consider the sanction of advice imposed on the practitioner in that particular case in which I held at para. 39 that:-

> "…[H]aving regard to the relatively mild sanction imposed in this case it is difficult to see how the applicant could invoke the decision of the Supreme Court in *Meadows v. Minister for Justice* [2010] 2 I.R. to argue that the sanction was disproportionate …."

Third, in relation to the submission that no adequate reasons had been furnished by the FPC for its decision, it was clear from the *Meadows* decision (at p. 261) that the extent of the obligation was that the essential rationale for the decision must appear. In the *McManus* case [2012] IEHC 350 (Unreported, High Court, Kearns P., 14th August, 2012), this Court held it was sufficient for the practitioner to know "how and why" a finding was made.

There is no obligation on an administrative tribunal to set out detailed reasons why it prefers one explanation to another. This had been made clear by Dunne J. in *Brennan v. An Bord Altranais* [2010] IEHC 193 (Unreported, High Court, Dunne J., 20th May, 2010).

The extent of any such obligation had to be measured in the context of the particular case. While the parties had agreed that reasons be sought and given for the decision, that could not alter or determine the legal obligation. In the instant case the issue was a very simple one namely, whether the two acts or omissions complained of met standards of competence. Thus the "why and wherefore" of the FPC reasoning was clear and unambiguous.

Finally, in relation to the complaint of want of fair procedures, it was urged on behalf of the respondents that nothing new had been added during the course of the hearing. The reference to systems failures simply provided the context in which the findings had been made. However, it could be conceded that the finding in relation to allegation number 8 was repetitious, but the subtending facts had led the FPC to make such a finding and it should not be quashed.

DISCUSSION

While multiple issues have been agitated and canvassed during the course of the hearing, the central and critical questions appear to this Court to be as follows:-

> (a) What constitutes "poor professional performance" as provided for by the Act?
>
> (b) Can a single error in writing up patient notes constitute "poor professional performance"?

(a) Poor Professional Performance

Section 2 of the Act of 2007 clearly relates the failure of the practitioner to standards of competence. Essentially, based on the ordinary and everyday understanding of that terminology, this would connote an assessment of whether the professional in question has the power, ability and capacity for the particular task in which he or she is engaged. The long title to the Act of 2007 indicates that the overall purpose of the Act is to "better ensure the education, training and competence of medical practitioners". However, s. 2 of the Act in defining "poor professional performance" may be taken as indicating what is meant by competence by reference also to the bracketed words ("whether knowledge and skill or the application of knowledge and skill or both"). (Emphasis added)

The Medical Council has itself developed rules for the assessment of a medical practitioner's knowledge and skill by means of an assessment process introduced by Medical Council – Rules for the Maintenance of Professional Competence (No. 2) S.I. No. 741 of 2011. That assessment process involves an extensive review of the practitioner's performance as an ongoing state of affairs.

Such a duty is expressly imposed on the first named respondent under Part 11 of the Act of 2007 (Maintenance of Professional Competence) where s. 91 (1) provides:-

> "It shall be the duty of the Council to satisfy itself as to the ongoing maintenance of the professional competence of registered medical practitioners."
>
> Subsection (7) of s. 91 then provides:-
>
> > *"Where, arising from the performance of its duty under subs. (1), the Council considers that a medical practitioner registered in the Specialist Division or the Trainee Specialist Division as being given every reasonable opportunity by the Council to improve the practitioner's professional performance but if his professional competence is found by the Council to continue to be below the standards of competence that can reasonably be expected for continued registration in the Specialist Division, or the Trainee Specialist Division, as the case may be, then the Council may make a complaint."*

Thus the provisions of the Act and the rules made by the Medical Council in January, 2011 focus in particular on the "maintenance of professional competence".

It is thus contended on behalf of the applicant that the supposed lapse or failure in any given case must not simply focus on a single lapse but rather must give rise to a question over the competence of the practitioner. Further, the failure must be one of "knowledge and skill" and not what was described in this case as an 'inadvertent slip of the pen'.

A useful discussion of what constitutes poor professional performance appears in Mills, Ryan, McDowell and Burke "*Disciplinary Procedures in the Statutory Professions*" at paras. 2.51 - 2.63 inclusive.

The authors begin by stressing that the term "poor professional performance" entails different considerations from those applicable to misconduct allegations. The falling short does not have to amount to misconduct: "the falling short in question therefore must be a significant one, but not a 'serious falling short'".

The authors note that the applicable English statutes refer to findings of "deficient professional performance", rather than poor professional performance.

Under the Medical Act 1983 in that jurisdiction, only "professional misconduct" was sanctionable by virtue of section 36. However, the Medical (Professional Performance) Act 1995, by s. 1 inserted an additional provision to s. 36 of the Medical Act 1983 to embrace the concept of professional performance which is "seriously deficient". That test was in turn superseded by the Medical Act 1983 (Amendment) Order 2002 which provided for inquiries by the Investigation Committee into whether a practitioner's fitness to practise is impaired and provided further as follows:-

> "Section 35 C (2) – A person's fitness to practise shall be regarded as 'impaired' for the purpose of this Act by reason only of –
>
> (a) misconduct;
>
> (b) deficient professional performance"

In this circuitous fashion, it seems to me that the relevant standards in the United Kingdom are similar to those provided for by the Act of 2007 although the word 'impaired' is not contained in s. 2 of the Act of 2007. Nonetheless, as accepted by counsel on both sides, the terms "deficient" and "poor" mean the same thing in effect.

The case of *R. (Calhaem) v. General Medical Council* [2007] E.W.H.C. 2606 (Admin) is thus of particular interest in this case.

This case involved an appeal by a consultant anaesthetist against a determination made by the fitness to practise panel of the General Medical Council to the effect that (a) the appellant's fitness to practise was impaired because of misconduct and deficient professional performance and (b) the appellant's registration should be suspended for three months.

At para. 39 of his judgment, Jackson J., having reviewed the authorities in that jurisdiction, derived five principles which he felt were relevant to the case before him as follows:-

> *"(1) Mere negligence does not constitute 'misconduct' within the meaning of section 35C (2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to 'misconduct'.*
>
> *(2) A single negligent act or omission is less likely to cross the threshold of 'misconduct' than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as 'misconduct'.*
>
> *(3) 'Deficient professional performance' within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.*
>
> *(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute 'deficient professional performance'.*
>
> *(5) It is neither necessary nor appropriate to extend the interpretation of 'deficient professional performance' in order to encompass matters which constitute 'misconduct'."*

The third and fourth principles are those which are relevant to the present analysis. I believe they are the appropriate principles for construing s. 2 of the Act of 2007 also.

Furthermore, given that the Act of 2007 provides that any finding of poor professional performance must result in the imposition of a sanction and, in the case of a sanction imposed under s. 71(a) of the Act of 2007, permits of no appeal, it does seem to this Court appropriate to imply or import a requirement that a single lapse or offence must achieve a threshold requirement of being "serious". Indeed, by reference to what has befallen the applicant by way of media reporting of this case and the references in such reporting to the earlier inquiry in 2010, the matter could hardly be more serious. Such an approach seems well justified having regard to the principles outlined by Keane J. (as he then was) in O'Laoire v. Medical Council (Unreported, High Court, Keane J., 27th January, 1995) when he stated (at p. 107):-

> *"Conduct which could not properly be characterised as 'infamous' or 'disgraceful' and which does not involve any degree of moral turpitude, fraud or dishonesty may still constitute 'professional misconduct' if it is conduct connected with his profession in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners."*

While, of course, the Act of 2007 changed the requirements which could justify the imposition of a sanction, the passage which then followed appears to me to be of considerable significance:-

> *"I do not attach any significance to the fact that the adjective 'serious' does not appear before 'professional misconduct' in s. 46(1)(a) unlike the provision under consideration in Doughty v. General Dental Council. Only conduct which seriously falls short of the accepted standards of the profession could justify a finding by the professional colleagues of a doctor (and a similar finding by this Court) of 'professional misconduct' on his part."*

These views lead into the second point which the Court will now consider.

(b) Can a single act or omission amount to 'poor professional performance'?

I would commence this portion of the discussion by again approving and adopting the principles outlined by Jackson J. in *Calhaem's* case. A single slip or error of a minor nature should not normally constitute poor or deficient professional practice. However, to exclude a grave error, albeit one occurring on a single occasion, would be to apply an interpretation which would undermine the purpose of the Act of 2007 and usher in a 'one free strike' scenario which would be inimical to the interests of both the medical profession and the public interest generally.

Section 2 of the Act contains no such words of limitation, and indeed by their reference to the "application" of knowledge and skill, the words may be taken as including all functions which the medical practitioner is obliged to perform in the course of medical treatment and preparation for same, including taking and maintaining clear and comprehensible notes and records.

In *McManus v. Fitness to Practise Committee of the Medical Council and Another* [2012] IEHC 350 (Unreported, High Court, Kearns P., 14th August 2012), this Court observed (at para.63):-

> *"I would have thought the keeping of accurate medical records was a matter of such basic importance to the discharge of the functions of any medical practitioner that no expert evidence on this topic would have been required or put forward by the Committee in the course of this inquiry. However inconvenient and burdensome it may be to write up medical reports accurately, such records constitute a vital safeguard for both medical practitioners and patients alike in any situation where it later becomes necessary to conduct any form of investigation as to what transpired during the course of a patient's treatment. Every practitioner must be taken as knowing that records may later be used in court proceedings or other investigations or inquiries and hence their importance is self evident."*

While in the instant case there is no suggestion whatsoever of wrongful alteration or falsification of notes, which would probably in most cases amount to misconduct, I cannot accept the contention that the error, which the applicant very properly admitted, can be characterised as a "mere slip of the pen" or of no importance because it was "simply an erroneous transcription of one word". History is full of examples of serious consequences which may attend simple transcription errors.

Dame Janet Smith considered the issue of a one-off serious episode of "negligence" in the fifth Shipman Inquiry Report, offering the view that an isolated or limited incident of negligence could not sensibly be described as serious professional misconduct and felt that such a case could fall through the net. She advocated that a further category should be added to the means by which impaired performance might be proved which could relate to one or more incident. (See Fifth Shipman Inquiry Report, 2004, paras. 25.70–25.71, pp. 953-4; para. 27.212, p. 1149–1150)

Though I am not conflating the concept of poor professional performance with a negligent act or omission, it seems to me that "poor professional performance" does encompass an isolated (though very serious) error, whether it be in treatment or as in this case, in the taking of notes which may form part of the documentation to be considered by the surgical team.

Was this a grave error? In terms of causation, I do not believe that case was ever made out. On the contrary, despite the initial error in writing up the patient's notes, the applicant booked the patient in for her operation using an accurate and precise description. He never wrongly diagnosed that condition as suggested in the FPC findings. He wrote a confusing note which of itself should have prompted further inquiry by others prior to the commencement of surgery.

The real problem in this case undoubtedly lay with the systems in operation in Crumlin Hospital at the time which did not permit the applicant's detailed description of the required procedure set out in the admissions card to be fully and properly transcribed. In fact, the system itself excised the words "upper frenulum release" from the system. Add to that the fact that the consent form accurately described the procedure and also the fact that a specific discussion took place between the mother of the child and the SHO and nurse who attended the operation which clarified precisely what was required, and one is forced to conclude, on any rational or reasonable basis, that the applicant's initial error was not causative of the subsequent damage. It seems to me the FPC should have treated the admissions card as a revision or recall of the earlier erroneous note. Furthermore, the surgical pause which finally took place before the commencement of surgery also failed to pick up from all of the sources outlined above the precise nature of the procedure envisaged by the applicant.

The applicant was never charged with organising, devising or being in charge of the systems in Crumlin Hospital at the relevant time, yet was held responsible for those shortcomings, which included a system whereby all three versions of frenulum release were characterised only as "tongue tie" operations.

Having reached that conclusion, *i.e.*, that the initial error was not causative of the damage in this case, could it nonetheless constitute poor professional performance by virtue of simply being sufficiently serious *per se,* notwithstanding the multiple opportunities which presented themselves for correcting the situation later and which were effectively ignored?

It seems to me only sensible that a non-causative lapse must be seen as less serious in character than the one which causes damage, in much the same way as one distinguishes between the failure of a motorist to give an indication to turn which has no harmful consequence and one which leads directly to a massive pile up and loss of life.

It seems to me that the question for consideration in a judicial review context can only now be resolved in the light of the Supreme Court decision in the case of *Meadows v. the Minister for Justice Equality & Law Reform* [2010] 2 I.R. 701 where the assessment necessarily involves asking the question whether the findings and sanction were proportionate on the facts of the particular case.

As stated by Murray C.J. in that case at para. 57 of his judgment:-

> *"In examining whether a decision properly flows from the premises on which it is based and whether it might be considered at variance with reason and common sense I see no reason why the court should not have recourse to the principle of proportionality in determining those issues."*

Again at para. 62 he stated:-

> *"It is inherent in the principle of proportionality that where there are grave or serious limitations on the rights and in particular the fundamental rights of individuals as a consequence of an administrative decision the more substantial must be the countervailing considerations that justify it. The respondents acknowledge this in their written submissions where it was stated:-*
>
> > *'Where fundamental rights are at stake, the courts may and will subject administrative decisions to particularly careful and thorough review, but within the parameters of O'Keeffe v. An Bord Pleanála [1993] 1 I.R. 39, reasonableness review.'*
>
> *In the same submissions the respondent stated, 'as to the test of reasonableness, the respondents have already made it clear that they have no difficulty whatever with the proposition that, in applying O'Keeffe v. An Bord Pleanála, regard must be had to the subject matter and consequences of the decision at issue and that the consequences of that*

decision may demand a particularly careful and thorough review of the materials before the decision maker with a view to determining whether the decision was unreasonable in the O'Keeffe v. An Bord Pleanála sense."

Applying this test to the facts of the instant case, I am satisfied that the FPC, with regard to allegation number 1, could and indeed was obliged, to make the finding of fact which it did, but was mistaken in characterising it as poor professional performance given that the error of the applicant was not a very serious one and made no real contribution to the eventual procedure carried out by Dr. Tareen. There is no evidence to warrant a finding that it did contribute or that the surgical team had any regard to it. What is clear is that the team had no regard to the multiple other sources of information which conveyed accurately the nature of the procedure required. In my view the unique and special circumstances of this individual case, including the serious consequences for the applicant and the absence of any right of appeal, do not pass a proportionality test which would support the imposition of the sanction in respect of allegation number 1.

In relation to allegation number 6, the applicant delegated the procedure to a competent delegate and this was accepted by all witnesses. The applicant delegated the task by reference to the theatre list. There was evidence before the FPC that any person to whom the applicant delegated the procedure would adhere to the hospital policy of conducting a surgical pause during the course of which the delegate would familiarise himself with the case notes prior to surgery. Given the circumstances of the communication (the applicant was hurrying away to deal with an emergency), I do not consider that a finding of poor professional performance could rationally be said to arise when the instruction given was so easily capable of being clarified by Dr. Tareen in advance of the specified procedure.

There is a further consideration which arises in this regard. It is evident that the FPC was inclined to the view that the true culprit in the instant case was a communications systems failure within the hospital. While these failures and shortcomings are extensively referred to in the findings of the FPC they formed no part of the allegations in respect of which the applicant was charged, including, in particular, allegation 6. In formulating its view on this charge, the FPC gave extensive consideration to shortcomings in the hospital protocols and systems and attributed blame to the applicant for his failure to recognise and work within what were characterised by the FPC as "known weaknesses of the system".

While the applicant obviously had a clinical responsibility for the patient under his care, it does not seem to me appropriate that he be disciplined for systems failures for which he has no direct responsibility.

I am thus also satisfied that, in a judicial review context, the FPC took into account, in a manner detrimental to the applicant, an irrelevant consideration whereby they attributed blame to the applicant for systems failures which were in reality those of the hospital in question. I would quash the finding here also on fair procedure grounds, because it formed no part of allegation 6, but yet seems to have in reality formed the basis for the finding made against him.

I further agree that the findings at allegation 8 are repetitious and cannot possibly stand in view of the findings I have made in relation to allegations 1 and 6 respectively. For that reason I would quash the findings in respect of allegation number 8 also.

CONCLUSION

In this judgment I have refrained from any extensive treatment of the evidence actually tendered at the hearing by the various witnesses, principally for the very simple reason that this is a judicial review procedure and not an appeal on the merits. Many of the applicant's submissions were addressed to the merits of the case and this in my view is not an approach to be encouraged in applications of this sort, although it is to some degree understandable given that no right of appeal exists in respect of the particular finding and sanction imposed on the applicant.

To the extent that it may remain necessary to record a view in relation to the supposed failure of the respondents to give reasons for their decision, I accept all of the respondents' submissions in relation to the giving of reasons. Whatever about its correctness in law or otherwise, the applicant could have been in no doubt as to the 'why's and wherefores' of the decision delivered.