THE HIGH COURT

JUDICIAL REVIEW

[2007 No. 252 J.R.]

BETWEEN

WALTER PRENDIVILLE

APPLICANT

AND

THE MEDICAL COUNCIL, IRELAND AND THE ATTORNEY GENERAL

RESPONDENTS

[2007 No. 260 J.R.]

BETWEEN

JOHN FRANCIS MURPHY

APPLICANT

AND

THE MEDICAL COUNCIL, IRELAND AND THE ATTORNEY GENERAL

RESPONDENTS

Judgment of Mr. Justice Kelly delivered the 14th day of December, 2007.

Introduction

1. Professor Walter Prendiville (Prof Prendiville) and Dr. John Francis Murphy (Dr. Murphy) both seek to quash decisions of the Medical Council (the Council) confirming a report of the Council's Fitness to Practise Committee (FPC) finding them guilty of professional misconduct. If necessary, they also seek to quash the report of the FPC. In the event of their applications for *certiorari* not being successful, they seek declaratory orders concerning the alleged unconstitutionality of certain provisions of the Medical Practitioners Act, 1978 (the Act). They also seek a declaration that those provisions of the Act are incompatible with the State's obligations pursuant to Article 6(1) of the European Convention on Human Rights and Fundamental Freedoms (the Convention). As these latter questions will only arise if the applicants fail to obtain *certiorari* on conventional grounds, consideration of them was, by agreement, postponed to await my findings on that issue.

2. There are many similarities between the two cases but they are not identical. Both applications for judicial review were heard together and joint submissions were made by the applicants.

Professor Prendiville

3. Professor Prendiville has had a distinguished medical career specialising in the field of obstetrics and gynaecology. He is an associate professor of obstetrics and gynaecology at the Royal College of Surgeons in Ireland and at the Department of Obstetrics and Gynaecology at the Coombe Women's Hospital in Dublin. He is chairman of the Department of Gynaecology at Tallaght Hospital and is a consultant in those hospitals. He has had a major research interest in the prevention of primary post partum haemorrhage. He has published widely in this field and has twice been an advisor to the World Health Organisation and a member of its task force on the subject. He has many publications to his name.

Dr. Murphy

4. Dr. Murphy is a consultant obstetrician and gynaecologist at both the National Maternity Hospital and St. Vincent's University Hospital in Dublin. He holds Fellowships of the Royal College of Physicians of Ireland and the Royal College of Obstetrics and Gynaecology. He has had a distinguished career for more than 40 years with over 50 articles to his name in peer reviewed publications. As a mark of the esteem in which he was held by his colleagues he was elected President of the Royal College of Physicians of Ireland but because of the decision of the Council in suit he felt obliged to resign from that position.

Events of November 1998

5. In November, 1998 the name of Dr. Michael Neary (Dr. Neary) was not well known, as it is now, to the general public. He was then a consultant obstetrician and gynaecologist at Our Lady of Lourdes Hospital in Drogheda. He had served in that capacity for many years and had an extensive public and private practice. He was a busy, hard working consultant operating a 1 in 3 rota at that hospital.

6. For a time both Dr. Neary and Dr. Murphy served on the Council of the Irish Hospital Consultants Association (IHCA). Dr. Murphy met him in that capacity and also at a number of medical seminars. It was his belief that Dr. Neary enjoyed a very sound professional reputation based on first hand reports which he had received from both medical colleagues and midwives attached to the Drogheda hospital and patients of his practice.

7. On the 3rd November, 1998 Mr. Finbar Fitzpatrick the Secretary General of the IHCA contacted Dr. Murphy. He told him that Dr. Neary had returned from leave and was about to be suspended on pay from his position as a consultant at the Drogheda hospital. That hospital had formerly been in the care of the Medical Missionaries of Mary but was taken over by the North Eastern Health Board. It was well known in medical circles that, since the time of that transfer of ownership, relations between the medical staff and that health board were very strained. Mr. Fitzpatrick told Dr. Murphy that the suspension of Dr. Neary was due to take place almost immediately notwithstanding the fact that a peer review of his practice was due to be carried out very soon by the Institute of Obstetrics and Gynaecology in Dublin (the Institute). The reason for all of this activity concerning Dr. Neary arose from a complaint, which had been made by a person who was not a patient, concerning the number of caesarean hysterectomies which he had performed over the previous few years.

8. Dr. Murphy took the view that the suspension of Dr. Neary (even on pay) pending the peer review of his work by the Institute would be devastating for him both personally and professionally and it seemed to Dr. Murphy that the process was unfair. Following two further telephone conversations with Mr. Fitzpatrick on the same day he agreed to assist the IHCA in the preparation of a report on Dr. Neary.

9. Having procured Dr. Murphy's agreement to become involved, Mr. Fitzpatrick then contacted Prof. Prendiville and persuaded him to do likewise. A third consultant obstetrician and gynaecologist, Dr. Bernard Stuart, subsequently agreed to become involved.

10. The three consultants were asked to submit their report within 72 hours. This was because of Mr. Fitzpatrick's belief that time was of the essence in the context of the health board threatening to apply to court for an order suspending Dr. Neary from his

employment. It was in this atmosphere of urgency that the three consultants undertook their task.

11. A number of other important features concerning the task being undertaken by the three consultants must be borne in mind. First, none of them had any experience of being asked to prepare a report in these circumstances and for such purpose. Secondly, there was no template or set of rules to which they could refer. Thirdly, the report was being prepared in an industrial relations context. Finally, it was the view of the three consultants that they were to prepare interim reports solely for the use of the IHCA in its dispute with the health board.

The Meeting with Dr. Neary
12. Mr. Fitzpatrick arranged for Dr. Neary to come to Dublin on the evening of the 3rd November, 1998. He attended at Dr. Murphy's house where there were present Prof. Prendiville, Dr. Murphy and Dr. Stuart. The meeting began at 7 o'clock and lasted for 4 hours.

13. Dr. Neary brought along photocopies of medical records of 17 patients. Dr. Neary explained that 8 of the patients had had hysterectomies carried out on an elective basis. They were not of any relevance from the point view of the preparation of the interim report. No issue turns on that.

14. Concentration was directed to the remaining 9 patients. Over the four hour period these cases were discussed and Dr. Neary was questioned in respect of them. He gave clear, comprehensive and coherent answers and explanations. He took the three consultants through his operating notes in respect of each of the patients. It was not possible in the time available to carry out any analysis of the other medical records, which in any event were not arranged in good order.

15. It was evident to the three consultants that Dr. Neary had a low threshold for carrying out peri partum hysterectomies (pph). The consultants were aware that no complaint had been made against Dr. Neary by any particular patient. They were *au fait* with the ethical code of the hospital which prohibited sterilisation even in situations where medical opinion was to the effect that further pregnancy would be life threatening. They also knew of the lack of availability of certain drugs, which would be readily to hand in the bigger Dublin maternity hospitals, to deal with severe post-partum haemorrhage.

16. They brought to Dr. Neary's attention the fact that he had a low threshold for intervention by way of pph. Because of that, the three consultants obtained from him an undertaking not to perform any further pph without a supporting opinion from a second consultant. The purpose of this undertaking was to protect Dr. Neary's patients pending the peer review due to be carried out by the Institute. The need for a peer review was clear and in any event had already been agreed to by Dr. Neary.

17. At the conclusion of the meeting Dr. Neary left, taking the copy charts with him.

18. Following the meeting, Prof. Prendiville, Dr. Stuart and Dr. Murphy began the preparation of their respective reports.

The Reports
19. The report of Prof. Prendiville is set forth in full at appendix 1 to this judgment. The report of Dr. Murphy is set forth in full at appendix 2 to this judgment. These reports speak for themselves. They supported the continuation of Dr. Neary in his work at the Drogheda hospital pending the review by the Institute. The purpose of these reports was to assist the IHCA and its legal advisors. The reports were sent by the IHCA to its solicitors, Daniel Spring and Co. who by a letter of the 6th November, 1998 sent them on a private and confidential basis to Mr. Gary Byrne solicitor of BCM Hanby Wallace, solicitors for the North Eastern Health Board. The covering letter enclosing the reports made it clear that they were being sent on the strict understanding that they were for the information of Mr. Byrne and the Chief Executive Officer of the North Eastern Health Board only and were not to be disclosed to any other parties without the permission of the authors to be obtained through Spring and Co.

The Health Board Response
20. Dr. Neary was not suspended from his employment at the Drogheda Hospital. He continued to work there and honoured his undertaking that he would not conduct any pph unless he obtained a second opinion confirmatory of the need for such a procedure.

21. The health board then commissioned Dr. Michael Maresh a consultant obstetrician and gynaecologist at St. Mary's Hospital, Manchester in England to conduct a review of the nine cases considered in the reports of Prof. Prendiville and Dr. Murphy. Dr. Maresh was furnished with statistics relating to the rates of obstetric hysterectomy in the Drogheda hospital from 1994 to 1998 and the rates for the Dublin maternity hospitals.

22. Dr. Maresh produced a report dated 3rd December, 1998. He spent several weeks preparing this report. He did not meet Dr. Neary in the course of its preparation. In evidence, which he gave to the FPC, he said that he had approximately 1200 pages of charts before him and that it took at least an hour to collate each of the 9 sets of notes and another four to six hours to draw his conclusions in respect of each case. He came to a different conclusion to Prof. Prendiville and Dr. Murphy concerning Dr. Neary. His report is set forth at Appendix 3 to this judgment. I have removed the names of patients from the reports in all these appendices to preserve patient anonymity.

23. Following Dr. Maresh's report, Dr. Neary was suspended from employment on December 11th, 1998. Thereafter the Council became involved. It sought his suspension from the practice of medicine under s. 51 of the Act and such an order was made by this court on 5th February, 1999. Dr. Neary resigned from the practice of medicine in June 1999 and has not practised since. A lengthy FPC hearing on his conduct took place and he was struck off the medical register in September 2003. Dr. Stuart, the co-author of Prof. Prendiville's report gave evidence on Dr. Neary's behalf before the FPC. The Chairman of the FPC thanked him for that evidence which was described as most helpful.

The Government Response
24. Such was the level of concern at what had occurred at the Drogheda hospital that the Government decided on the 6th April, 2004 to set up a non-statutory private inquiry (the Inquiry) into the events at the hospital. Of particular concern was the rate of pph at the Drogheda hospital and Dr. Neary's practice in that regard. The Inquiry also covered whether his practice was commented on or acted upon by consultants or other medical staff or the management of the hospital. The Inquiry was conducted by Judge Harding Clark S.C. (now Harding Clark J.). It reported in January 2006.

The Inquiry's Report
25. Two particular statements contained in para. 1.8 of the Introduction and Overview to the Inquiry's report have given rise to great concern and a sense of an injustice having been done to them on the part of Prof. Prendiville and Dr. Murphy. These statements also triggered the events which have given rise to this application for judicial review.

26. In dealing with the reports prepared by Prof. Prendiville and Dr. Murphy on Dr. Neary the Inquiry said this at para. 1.8:-

> "The Inquiry accepts that permitting Dr. Neary to work pending the review by the Institute of Obstetricians and Gynaecologists may well have been the intention of his union advisors and his three colleagues in presenting their report. The report may have been prepared for limited viewing but the language, which is not qualified, is regrettable. I believe that the three obstetricians involved have had serious regrets for their part in producing these reports, which were motivated by compassion and collegiality. They ought to have been alarmed that one obstetrician carried out seventeen caesarean hysterectomies in three years in a middle sized Maternity Unit notwithstanding the lack of tubal ligations, a vascular surgeon or the use of prostaglandins.
>
> As a result of their report, Dr. Neary returned to work - subject to restrictions - and the health board sought the views of an independent specialist outside the jurisdiction."

27. Neither applicant accepts the characterisation of the language of their reports as being "not qualified". Neither do they accept that in producing these reports they were motivated by compassion and collegiality.

28. It is clear that the judge, prior to finalising her report, followed a course which is now well established as a matter of fair procedures by tribunals of inquiry in cases such as this one. She furnished to persons to be criticised in the report a draft of that criticism in advance of its finalisation and publication. This was to enable such persons to make submissions and observations on that criticism before the final report was produced.

29. Whilst that procedure was apparently followed for everyone else, it was not followed in the case of either Prof. Prendiville or Dr. Murphy. They are aggrieved that they were so treated.

30. The matter is neatly summarized by Prof. Prendiville at para. 15 of his affidavit sworn on the 8th March, 2007 where he says:-

> "I am afraid that I cannot agree with Ms. Justice Harding Clark that the report was prepared out of compassion or collegiality. It was not. It was prepared on the basis of the information made available to me and I had no reason to doubt the veracity of the account given to me by Dr. Neary. Furthermore, I have no recollection of ever expressing regret for my role in preparing the report. These were not observations that I had an opportunity to make to Ms. Justice Harding Clark, as, unlike other persons criticised in her report, I was not provided with a copy of her draft report. Otherwise, I would certainly have made my position on the contents of para. 1.8 of her report known to Ms. Justice Harding Clark."

31. Neither the report of Harding Clark J. nor the procedures followed by her pertaining to the applicants fall for consideration in this judicial review. It is however clear that both applicants believe they were unfairly dealt with by the Inquiry and as para. 1.8 of the report was the genesis for the matters that I have to consider, their sense of injustice has not diminished as events have developed.

The Medical Council Involvement

32. As a result of the findings of the Inquiry, a group known as Patient Focus made a complaint to the FPC concerning the three consultants who had prepared interim reports into the conduct of Dr. Neary. The Patient Focus complaint was dated the 20th March, 2006. On foot of it, the Council wrote to the applicants informing them of the complaint and inviting observations from them. Both applicants responded.

33. Subsequent to the making of the complaint by Patient Focus the Council itself considered the Inquiry's report. It decided to apply to the FPC for an inquiry into the conduct of the applicants. That decision was made on the 21st March, 2006. The decision was the subject of a press statement issued by the President of the Council which announced the application for an inquiry and inter alia emphasised the "ethical imperative there is on all Medical Practitioners to deal with underperforming colleagues rapidly and fairly in a way that always keeps the safety of patients as the prime goal". Although that press statement was published on the 21st March, 2006 it was not until the 2nd May, 2006 that any official notification was sent to the applicants concerning the decision of the Council. On that occasion, they were notified of the Council's complaint and were again asked for their observations and they responded.

34. On the 29th June, 2006 the FPC considered the complaint of the Council and concluded that there was a *prima facie* case for holding an inquiry under Part V of the Act. At a further meeting of the FPC held on 25th July, 2006 it considered that a prima facie case for the holding of an inquiry under Part V of the Act was made out in respect of the Patient Focus complaint.

35. As a result of these decisions the Registrar of the Council prepared Notices of Inquiry setting out allegations of professional misconduct against Prof. Prendiville and Dr. Murphy. These notices are appendices 4 and 5 to this judgment.

The FPC Hearing

36. The hearing of the allegations against the applicants took place before the FPC on November 29th and 30th and December 1st and 20th, 2006. The FPC was chaired by Mr. Brendan Healy. He sat with Dr. Miriam Hogan, Professor Arthur Tanner, Professor Anthony Cunningham and Dr. Deirdre Madden. All but Dr. Madden are registered medical practitioners. Mr. Kevin Cross SC was legal assessor to the FPC. Both applicants were represented by Senior Counsel.

37. Reports were prepared and evidence was lead from Dr. Maresh and Dr. Peter McKenna on behalf of the Registrar of the Council who prosecuted the complaints. Mr. Finbar Fitzpatrick likewise gave evidence.

38. Prof. Prendiville, Dr. Murphy and Dr. Stuart gave evidence on their own behalf. Evidence from Dr. Patricia Crowley and Dr. Peter Lenehan was led on behalf of Prof. Prendiville and Dr. Stuart. Dr. Malachy Coughlan gave evidence on behalf of Dr. Murphy.

39. By letters of the 15th January, 2007, each applicant was provided with a report of the FPC purportedly prepared pursuant to s. 45(3)(c) of the Act. The report was dated the 12th January, 2007. It is appendix 6 to this judgment.

40. In the case of Prof. Prendiville of the twelve allegations of professional misconduct made against him, the FPC found by a majority that allegations 1, 3, 5, 9, 10 and 11 had been proved. It found that allegations 1, 3, 5, 10 and 11 as proved did not amount to professional misconduct. By a majority, it found that allegation 9 as proved did amount to "professional misconduct as defined by Keane J. in *O'Laoire v. The Medical Council* being conduct in connection with his profession in which the medical practitioner has seriously fallen short of the standards of conduct expected among medical practitioners and not in a sense of any 'infamous' or 'disgraceful' conduct or any conduct involving any degree of moral turpitude, fraud or dishonesty."

41. In the case of Dr. Murphy, the FPC found by a majority that allegations 1, 3, 5, 8, 9 and 10 were proved. It found that allegations 1, 3 and 5 as proved did not amount to professional misconduct. By a majority it found that allegations 8, 9 and 10 as proved did amount to professional misconduct. The FPC used precisely the same formula in describing the professional misconduct on the part of Dr. Murphy as it did in respect of Prof. Prendiville.

42. In the case of Prof. Prendiville, the FPC recommended that he be advised that should he have any reservations in any future report undertaken then those reservations should be included in his report. (The actual formulation of this recommendation in the FPC report contains an error in that it refers to Dr. Stuart but no point is taken in respect of that).

43. In the case of Dr. Murphy, the recommendation to the Council was that he should be admonished in relation to his professional conduct.

44. The letter accompanying the report of the FPC invited both applicants to attend before the Council on the 6th February, 2007, to "afford you the opportunity to make a submission to the Council before it reaches a decision in accordance with part V of the Medical Practitioners Act 1978".

The Meeting of the Council
45. The meeting of the Council took place on the 6th February, 2007 and both applicants were present at it and were represented by counsel. Twenty-two members of the Council were present. All five members of the FPC who heard the complaints against the applicants were present and participated in the Council's deliberations. Professor Arthur Tanner's name does not appear on the transcript but he was in fact at the Council meeting.

46. At the outset of the meeting it became clear that the members of the Council had not been provided with a copy of the reports which had been prepared by Professor Prendiville and Dr. Murphy in November, 1998 and which were the subject of the FPC inquiry. These reports were only then furnished to the Council members. The explanation for the fact that the Council members did not have the reports was given by the President of the Council where he said:-

> "Normally the Council just receive the transcripts and do not get the exhibits, just receive the report of the Inquiry team (sic) so the Council does not have copies of the original reports. I think the basis of that is that the Council has to accept the report of the inquiry team and then to listen to submissions and decide as to sanction." (my emphasis)

47. I read the reference to "inquiry team" as meaning the FPC.

48. Thus, at the very outset of the Council meeting, the President was clearly of the view that the meeting was confined to the question of sanction and had to accept the findings of the FPC on professional misconduct.

49. That view was confirmed by a further comment from the President of the Council made shortly after the one which I have just quoted and before any submissions had been heard from counsel on behalf of either applicant. The comment came in circumstances where counsel for Professor Prendiville, having circulated the reports, indicated that it would be an injustice to reach any conclusion of any kind without having very carefully considered them. He invited the Council not to rush to judgment without considering everything that was relevant. The President said:-

> "Thank you Mr. Butler. First of all in relation to your last remark, we will not be rushing to judgment. The inquiry team (sic) has made a decision and we will be accepting the inquiry team's decision." (my emphasis)

50. These observations of the President make it clear as to what his state of mind was concerning the exercise which was being undertaken by the Council on the afternoon on the 6th February, 2007. The Council was to consider only the question of what sanction, if any, was to be visited on the applicants.

51. It is clear from the submissions made by counsel on behalf of the applicants on that occasion that they did not see the role of the Council as being confined only to the question of sanction. Rather they made submissions to the effect that the Council ought, for a variety of reasons advanced, to refuse to accept the substantive findings of the FPC.

52. Subsequent to making their submissions counsel on behalf of both applicants withdrew from the meeting to allow the Council members to deliberate.

53. There remained in the room two persons who had been present throughout the meeting. They were the Registrar of the Council (in whose name the complaints against the applicants had been prosecuted before the FPC) and an in-house legal advisor Mr. William Kennedy. During the course of the meeting, both of these gentlemen spoke privately to the President of the Council. As they did not withdraw at the same time as the legal teams representing the applicants, neither Professor Prendiville nor Dr. Murphy were aware of what transpired thereafter. In particular, they were not aware of whether any legal advice was sought by, or given to, the Council on two important matters which had been the subject of submissions on their behalf. They were:

> a) the obligation of the Council to consider submissions and, if appropriate, to refuse to accept the FPC findings on guilt (the applicants argued that such a course was appropriate); and
>
> b) the proper definition of professional misconduct.

54. It was not until the applicants had sight of the replying affidavit sworn by the President of the Council in these proceedings that the applicants became aware of what actually happened after they and their lawyers withdrew at the conclusion of their submissions to the Council. It is dealt with in para. 44 of the President's affidavit sworn in Professor Prendiville's proceedings. There Dr. Hillery says:

> "As appears from the transcript, the applicant's counsel urged the first respondent to reject and effectively overturn the decision of the Fitness to Practise Committee. After a detailed discussion, the meeting adjourned, and the Vice President of the respondent Dr. Colm Quigley and I met with the registrar of the first respondent, Mr. John P. Lamont, and the first respondent's in house legal advisor, Mr. William Kennedy, to discuss the suggestion made by the applicant's counsel that the first respondent could reject the findings of the Fitness to Practise Committee. I submit that there is nothing improper about meeting with the first respondent's officers in this way, and there was no want of fair procedures in the fact that the applicant's lawyers were not part of this meeting. At the meeting, we discussed the suggestion made by the applicant's counsel, and were advised by Mr. Lamont and Mr. Kennedy that the function of the first respondent was to

consider the report of the Fitness to Practise Committee, and decide as to sanction and publication. The meeting of the first respondent then reconvened, and following some further discussion, it was decided that no sanction would be imposed on the applicant(s) but that the report of the Fitness to Practise Committee would be published."

55. A similar paragraph is sworn in the replying affidavit to Dr. Murphy's judicial review application.

56. The Council reconvened at the conclusion of its deliberations and announced through its President that it had "decided to accept the verdict (sic) of the Fitness to Practise Committee in each case but to impose no sanction in any case". He also announced that it had decided to publish this decision by way of a press release and to make available the transcripts of the inquiry on the Council website as soon as arrangements could be made to suitably "anonymise" (sic) the transcripts as regard patient information.

57. The press release that was issued through a public relations company was extraordinary. It recorded the decision to "accept the findings of professional misconduct" against the applicants but did not record the decision of the Council not to impose any sanction against them. It is quite clear that the Council took the view that it could do nothing other than accept the FPC findings on all but penalty. Why the statement should record the decision on which the Council had, according to itself, no discretion and not record the only issue on which it had discretion and which was favourable to the applicants is bizarre. It was very unfair to the applicants who were entitled to expect better from the Council.

Effect of Council decision

58. A finding of professional misconduct against any professional person is very serious. It has had profound consequences for the applicants in the present case.

59. Prof. Prendiville, at paragraph 33 of his grounding affidavit, gives the following uncontroverted testimony.

> "I am distressed and embarrassed by the FPC finding and the respondent's decision, which I believe to be unwarranted, and by the extent of the publicity surrounding it. I am distressed not only for myself but also for my family. In particular, my family is upset at the calls made in certain quarters that I should not be permitted to practise as a doctor at all. I have dedicated my professional life to the care of pregnant women for more than three decades now. While I readily acknowledge the deep hurt and trauma experienced by the women represented by, for example, Patient Focus and their families, I nonetheless consider the finding of professional misconduct made against me by the Medical Council to be unfounded and irrational. The effects on my professional reputation and my career of the respondents action in finding me guilty of professional misconduct will be profound and longstanding. I have been described in the press and in the Oireachtas as a disgrace to the medical profession."

60. That affidavit was sworn on the 8th March, 2007.

61. Prof. Prendiville's forebodings proved to be correct. In a subsequent affidavit sworn by him on the 18th July, 2007 he outlined what he described as the "identifiable adverse effects" of the decision in suit upon him. On the 20th February, 2007 the Royal College of Surgeons in Ireland wrote to him indicating that his continued involvement in its teaching programmes would need to be reviewed in the light of the decision of the Council. He requested that any such review should await the outcome of these proceedings and the college agreed to do so. He says that his continued involvement in the teaching programme of the Royal College of Surgeons in Ireland is fundamental to his position as an associate professor.

62. He was also a member of the most recent Irish Cervical Screening Committee having served on a number of such committees in the past. He has been asked by the chairman of the committee to consider his position as a committee member. He did not consider it appropriate to resign as a member of the committee. Subsequently, responsibility for the Irish Cervical Screening Programme was transferred to Breast Check. He was not invited to become a member of the newly constituted committee.

63. The Irish Cervical Screening Programme recently advertised for the position of lead colposcopist/chair of the colposcopy quality assurance committee. He applied for that position. However the chief executive officer of that body telephoned him to say that he would not be appointed to the position and that the reason for so doing was the decision of the Council in suit.

64. As part of Prof. Prendiville's continued involvement in national and international postgraduate education he has been running postgraduate clinical skills training courses for the last 15 years. As the technical demand of surgical training increased, he felt it was necessary to set up a national clinical skills centre. To do that, he sought and obtained funding from the Royal College of Surgeons in Ireland, the Institute, the Coombe Hospital, the Health Service Executive and the Postgraduate Medical and Dental Boards. The centre was opened in late June and, as it was he who had proposed and then established it, he became its foundation director. On the 23rd June of this year his involvement with the centre was the subject of an editorial and a front page article in the Examiner newspaper. These articles made reference to the views expressed in certain quarters that he should consider whether he and Dr. Murphy are fit to continue teaching medical students. The newspaper concluded that it should be asked why he was appointed to the position in advance of the determination of this court.

65. In the case of Dr. Murphy he, in his grounding affidavit said:

> "The effects on my professional reputation of a finding of professional misconduct (however defined) have caused me profound professional and personal embarrassment, and this will endure for the rest of my life. It will mean that for the residue of my professional career, I will be operating under a cloud of suspicion. It will mean that I will be deemed unworthy to offer professional opinion on a medico legal matter in court, and of course I will be unable to furnish any further publications for peer review, or address any seminars. As this honourable court will appreciate, these tasks are undertaken by members of the profession for the enhancement of the profession, and not for reasons of vanity or otherwise."

66. In a subsequent affidavit sworn by him on the 20th July, 2007 he said as follows:-

> "At the time of the inquiry conducted by the respondent I had been elected president of the Royal College of Physicians of Ireland, perhaps the highest honorary position in medicine in the country. As a direct result of the decision of the respondent, I felt it necessary to resign this position which was personally humiliating and upsetting for both myself and my family. It is my belief that I will not be asked to sit on important boards involving my profession or to chair meetings with my peers, nor do I believe that I will be requested to offer a medico legal opinion in court proceedings, so long as the decision of the respondent remains. Quite clearly, this will have a profound effect on my professional reputation and standing.

I say that in addition to the foregoing, the media attention since the first announcement of an inquiry into three un-named obstetricians has been huge and intrusive. I say that I work in a highly personal speciality where reputation is of the utmost importance. As a result of my involvement in this inquiry I believe that I have been the subject of extensive comment by patients, staff and the public in general. The decision of the respondent has had a highly corrosive effect on both myself and my family, and has also affected my relationship with friends and colleagues. In my view, the decision has had the effect of negating much of the effort and work I have been engaged in in my profession over the past four decades."

67. In his replying affidavit the President of the Council asserts that in circumstances where a decision not to impose a sanction of erasure or suspension or attachment of conditions was arrived at, the right of the applicants to practice medicine has not in any way been infringed. It is of course true that there is no legal restriction on them but such an approach is highly artificial and takes no account of the practical consequences of the findings upon them and their professional reputations. There can be no doubt that they have sustained considerable damage to their standing, reputation and the practise of their profession.

68. In these circumstances, it is hardly surprising that the applicants sought to appeal the decision of the Council.

The Appeal
69. As the applicants were dissatisfied with the decision of the Council, they sought to appeal the decision to this court in purported compliance with the provisions of Part V of the Act.

70. The applicants were met with an objection on the part of the Council to the effect that no such appeal lies to the court having regard to the wording of sections 46, 47 and 48 of the Act.

71. In short, those statutory provisions only provide for an application being made for the cancellation of a decision of the Council in circumstances where it has decided to erase or suspend the name of a medical practitioner from the register or to attach conditions to the retention of that person's name in the register. In circumstances where it decides to advise, admonish or censure the medical practitioner or to impose no penalty (as in the present case) no appeal on the merits lies to this court.

72. The applicants ultimately accepted this to be the position and consequently applied for judicial review. Were the position otherwise it is clear that this court could consider the Council's case against the applicants on its merits as was done most recently by Finnegan P. in *O'Connor v. Medical Council* (17th July, 2007) where that judge cancelled the decision and findings of professional misconduct made against the appellant doctor.

73. Quite clearly judicial review was very much a "second choice" on the applicants part because of its narrower remit and the inability of the court to address the substantive merits of their case.

Judicial Review
74. The applicants complain that the Council misdirected itself as to its jurisdiction and acted *ultra vires* in following the legal advice tendered to it to the effect that it was obliged to confirm the findings of the FPC and confine itself solely to the question of penalty. Not merely was the legal advice which was offered incorrect but the procedure which was followed in giving such advice was defective, they say.

75. This is not the only procedural objection which is taken. It is contended that the Council was wrong in law in permitting members of the FPC who adjudicated upon the complaint against the applicants to sit as members of the Council which considered the findings of that FPC. Furthermore, it is alleged that the Council was guilty of an illegality in failing to provide any reasons for its decision.

76. Complaint is also made that an incorrect standard of professional misconduct was applied by the FPC and the Council. Criticism is also made of the FPC for the paucity of information or reasoning in its report.

77. Finally it is said that both the FPC in its findings and the decision of the Council was unreasonable and irrational having regard in particular to the evidence or indeed lack of it to support such findings.

78. I must now turn to a consideration of these arguments. Before doing so, it is necessary that I sketch out the statutory scheme insofar as it is relevant to them.

The Act
79. In its long title the Act describes itself as being one to provide for the setting up of a Council known as the Medical Council which is to provide for the registration and control of persons engaged in the practice of medicine and to provide for other matters relating to the practice of medicine and the persons engaged in such practice. It consists of 69 sections divided up into six parts together with four schedules.

80. It is Part II of the Act which sets up the Council. It is constituted as a body corporate with perpetual succession and is, subject to the provisions of the Act, entitled to regulate its own procedure (see section 6).

81. Section 9 of the Act provides that the Council is to consist of 25 members appointed in the manner prescribed by that section. Section 13 of the Act deals with committees of the Council. It provides as follows:-

"13. – (1) The Council may, subject to the subsequent provisions of this section, from time to time establish committees to perform such, if any, functions of the Council as, in the opinion of the Council, may be better or more conveniently performed by a committee, and are assigned to a committee by the Council.

(2) In particular and without prejudice to the generality of subsection (1) of this section, the Council shall-

(a) establish a committee to act in relation to its functions pursuant to part IV of this Act, and

(b) establish a committee to act in relation to its functions pursuant to part V of this Act.

(3) A committee established under this section, other than the committee referred to in subsection (2)(b) of this section may, if the Council thinks fit, include in its membership persons who are not members of the Council.

(4) The chairman of every committee established under this section shall be a member of the Council provided that in the case of the committee referred to in subsection (2)(b) of this section the chairman shall be a member of the Council other than the President or the Vice-President of the Council.

(5) The committee established under subsection (2)(a) of this section shall include in its membership each person appointed to the Council pursuant to section 9(1)(a) of this Act.

(6) Every member of the committee referred to in subsection (2)(b) of this section shall be a member of the Council and –

a. a majority of the members of such committee shall be persons who have been appointed by election to the Council and

b. at least one member of such committee shall be a person other than a registered medical practitioner who has been appointed to the Council by the Minister pursuant to section 9(1)(g) of this Act.

(7) The acts of a committee established under this section shall be subject to confirmation by the Council unless the Council at any time, dispenses with the necessity for such confirmation.

(8) The Council may, subject to the provisions of this Act, regulate the procedure of committees established under this section, but, subject to any such regulation, committees established under this section may regulate their own procedure."

82. It is to be noted that the Council is obliged to set up a committee in relation to its functions pursuant to part V of the Act. That committee is given the title of the "Fitness to Practise Committee" pursuant to s. 2 of the Act.

83. Part V of the Act deals with fitness to practise. It consists of 11 sections running from sections 45 to 55 of the Act inclusive.

84. Section 45 provides that the Council or any person may apply to the FPC for an inquiry into the conduct of a registered medical practitioner on the grounds of his alleged professional misconduct or his fitness to engage in the practice of medicine by reason of physical or mental disability. Such an application must, subject to the provisions of the Act, be considered by the FPC (see section 45(1)).

85. Section 45(2) provides as follows:-

"Where an application is made under this section and the Fitness to Practise Committee, after consideration of the application, is of opinion that there is not sufficient cause to warrant the holding of an inquiry, it shall so inform the Council and the Council, having considered the matter, may decide that no further action shall be taken in relation to the matter and shall so inform the Committee and the applicant, or it may direct the Committee to hold an inquiry into the matter in accordance with the provisions of this section."

86. Subsection (3) reads:-

"Where an application for an inquiry is made under this section and the Fitness to Practise Committee, after consideration of the application, is either of opinion that there is a prima facie case for holding the inquiry or has been given a direction by the Council pursuant to subsection (2) of the section to hold the inquiry, the following shall have effect

(a) the Committee shall proceed to hold the inquiry

(b) the Registrar, or any other person with leave of the Fitness to Practise Committee, shall present to the Committee the evidence of alleged professional misconduct or unfitness to practise by reason of physical or mental disability, as the case may be,

(c) on completion of the inquiry, the Committee shall embody its findings in a report to the Council specifying therein the nature of the application and the evidence laid before it and any other matters in relation to the registered medical practitioner which it may think fit to report including its opinion, having regard to the contents of the report, as to –

(i) the alleged professional misconduct of the registered practitioner or

(ii) the fitness or otherwise of that practitioner to engage in the practice of medicine by reason of his alleged physical or mental disability

as the case may be.

87. Subsection (4) reads:-

"When it is proposed to hold an inquiry under subsection (3) of this section the person who is the subject of the inquiry shall be given notice in writing by the Registrar sent by pre-paid post to the address of that person as stated in the register of the nature of the evidence proposed to be considered at the inquiry and that person and any person representing him shall be given the opportunity of being present at the hearing.

(5) The findings of the Fitness to Practise Committee on any matter referred to it and the decision of the Council on any report made to it by the Fitness to Practise Committee shall not be made public without the consent of the person who has been the subject of the inquiry before the Fitness to Practise Committee unless such person has been found, as a result of such inquiry, to be –

(a) guilty of professional misconduct, or

(b) unfit to engage in the practice of medicine because of physical or mental disability,

as the case may be."

88. Subsection 6 invests the FPC with certain powers, rights and privileges vested in the High Court. Subsection 7 makes it an offence for a person not to respond to a summons issued by the FPC. Subsection 8 provides for immunities and privileges for witnesses before the FPC identical to those which apply to witnesses before this court.

89. Section 46 provides that where a registered medical practitioner has been found by the FPC, on the basis of an inquiry and report pursuant to s. 45, to be guilty of professional misconduct or to be unfit to engage in the practice of medicine because of physical or mental disability, the Council may decide that the name of such person should be erased from the register or that, during a period of specified duration, registration of his name in the register should not have effect. When such a decision is made by the Council it is obliged to send notice of it to the medical practitioner to whom the decision relates. That person then has a period of 21 days within which to apply to this court for cancellation of the decision and if he so applies this court is empowered to either cancel the decision or declare that it was proper for the Council to make a decision under the section in relation to such person and either direct the Council to erase his name from the register or direct that during a specified period the registration of his name in the register shall not have effect.

90. Under subs. (4) it is provided that in the case of a person to whom a decision of the Council under the section relates not applying to the High Court within time for cancellation of the decision then the Council is entitled to apply ex-parte for confirmation of such decision. Upon such an application, this court is obliged, unless it sees good reason to the contrary, to confirm the decision and direct erasure or suspension from the register.

91. The decision of the High Court on an application under s. 46 is final save that, by leave of this court or the Supreme Court, an appeal by the Council or the person concerned from the decision shall lie to the Supreme Court on a specified question of law.

92. Under subs. (7) the name of any person which has been erased from the register may be restored to it by direction of the Council but not otherwise. Upon such restoration the Council may attach such conditions as it thinks fit.

93. Under subs. (9) it is provided:-

> "On the hearing of an application under this section, the High Court may, if it thinks proper to do so, admit and have regard to evidence of any person of standing in the medical profession as to what is professional misconduct."

94. Section 47 entitles the Council, following an inquiry and report by the FPC pursuant to s. 45, to decide to attach conditions to the retention in any register maintained under the Act of a person whose name is entered on such register. The practitioner must be given notice of this and again is provided with a period of 21 days in which to apply to this court for cancellation of the decision. The High Court is empowered, on the hearing of such application, to either cancel the decision or declare that it was proper for the Council to make it. If the court considers it proper, it can direct the Council to attach such conditions as the court thinks fit to the retention of the name of such person in any register maintained under the Act. Again, as under s. 46, if a person to whom a decision of the Council under s. 47 relates does not apply to the High Court for cancellation of the decision the Council may apply ex-parte to the court for confirmation of it.

95. Section 48 provides that the Council, following an inquiry and report by the FPC pursuant to s. 45 into the conduct of a person on the register may, on receipt of the report of the FPC, if it so thinks fit, advise, admonish or censure such person in relation to his professional conduct. Under s. 48(2) it is provided that the powers conferred by subs. (1) may be exercised either in addition to or in substitution for any of the powers conferred by s. 46, 47 and 49 of the Act.

96. Section 49 deals with the topic of erasure from the register of persons convicted of indictable offences. It is the Council which makes such a decision but a person affected by it has a right to apply to this court for its cancellation. The court may cancel or confirm the decision. Section 53 deals with erasure or suspension from the register of medical specialists. Section 54 obliges the Council to notify the Minister of the erasure, restoration, suspension or termination of a period of suspension or the attachment of conditions to the retention of the name of any person on a register maintained under the Act. Section 55 deals with the restoration to the register of the name of a person removed from it.

97. It is the above sections which I have either summarised or set forth in full which fall for consideration in this judgment.

The respective roles of the FPC and the Council

98. The applicants contend that the Council acted ultra vires in considering itself bound to confirm the substantive decision of the FPC. They do not contend that the Council was obliged to conduct a rehearing of the matter that had been rehearsed extensively before the FPC. Rather they argue that it ought to have considered the arguments and submissions made by them as to why the majority finding of the FPC was flawed and ought not to be confirmed. It is clear from the evidence that the President of the Council at the outset was of the view that it could not so conduct itself. The legal advice which was proffered to the Council was to like effect and it is clear that the Council did not consider that it was open to it to adopt such a course. Rather it confined itself to a consideration of what penalty, if any, ought to be imposed having regard to the findings on the merits made by the FPC.

99. In so behaving, the applicants contend that the Council behaved unlawfully. By such behaviour, the applicants were denied the opportunity of having any aspect of the merits of their cases examined by the Council. As no appeal lies to this Court, the merits of the applicants' cases were considered by the FPC and it alone.

100. The nub of the applicants' case turns upon the provisions of s. 13(7) of the Act. It provides that the acts of a committee established under the section "shall be subject to confirmation by the Council unless the Council at any time, dispenses with the necessity for such confirmation".

101. It is clears that the FPC is a committee established under the section. It is established under s. 13(2)(b). Prima facie therefore, the acts of the FPC are subject to confirmation by the Council. There is no evidence that the Council ever at any time dispensed with the necessity for such confirmation. Indeed if it had done so, I would have expected it to have figured in the forefront of the response, not merely to this application, but during the hearing before the Council.

102. The applicants argue that if the decision of the FPC is subject to confirmation by the Council under s. 13(7) that must mean that

it can refuse confirmation. It may confirm the decision or, at its option, refuse to do so. In so doing it must exercise an independent judgment. It is not a mere cypher or rubber stamp. It must be open to, and consider on their merits, submissions made (such as was the case here) as to why it ought not to confirm a decision of the FPC. This does not involve it in having to re-hear evidence or hear new evidence. But it does involve it in having to consider arguments as to why, on the basis of the evidence tendered, the FPC ought not to have found as it did. In the present case the Council shut out any such possibility, regarded itself as bound by the findings of guilt made by the FPC and concentrated solely on the question of what penalty, if any, should be visited upon the applicants.

103. The Council argues that it was perfectly correct in adopting this approach. It says that that is so by reference to certain of the statutory provisions and a body of case law. The Council contends that the applicants' argument can only have validity if one considers the provisions of s. 13 and in particular subs. (7) thereof in isolation from the rest of the Act and in particular the provisions of ss. 45 to 48 thereof. The Council contends that those sections set out in detail the roles of the Registrar, the FPC and the Council.

104. That is of course true but nowhere in these sections is there any suggestion that the provisions of s. 13(7) are not applicable to the FPC. Indeed, the opposite is the case. The sections make it clear that findings of the FPC are at all times subject to a report being made by it to the Council and the Council making a decision on such findings. I find nothing in Part V of the Act to suggest that the FPC is anything other than a committee of the Council and as such subject to the provisions of s. 13(7) of the Act.

105. The high water mark of the case on statutory construction which is made by the Council is to be found in the specific provisions of s. 45(2). The Council argues that if the applicants are correct those statutory provisions would be unnecessary. Section 45(2) deals with a situation where the FPC forms the opinion that there is not sufficient cause to warrant the holding of an inquiry. In such circumstances it has to so inform the Council. The Council, having considered the matter, may decide that no further action shall be taken in relation to it or may direct the FPC to hold an inquiry into the matter in accordance with the provisions of s. 45.

106. It seems to me that s. 45(2) has as its principal object the conferring of an additional power on the Council in circumstances where it differs from the view of the FPC that there was insufficient cause to warrant the holding of an inquiry. The sub-section confers a power of remittal on the Council to send the matter back to the FPC with a direction to hold an inquiry. No such power is given by s. 13(7) which requires the Council either to confirm or not a decision of the FPC. Section 13(7) contains no entitlement to remit a matter to the FPC and so such is provided for expressly in s. 45(2). While s. 45(2) does say that the Council may in effect confirm the decision of the FPC by deciding that no further action shall be taken in relation to the matter, that is doing no more than describing the entitlement which is contained in s. 13(7) i.e. to confirm the FPC report. It is not strictly necessary to do so but it is reasonable that the legislature would elucidate the full entitlements of the Council in circumstances where an additional entitlement to remit to the FPC is being created.

107. The Council also argues that the applicants' approach is completely at variance with the case law which has developed on the interpretation of the Act. In a moment I will consider the cases relied upon by the Council. It is, however, important that I should point out that it appears that this is the first challenge of its type that has been made to the procedures followed by the Council in the almost 30 years since Act came into operation. A number of arguments are made which have not figured in previous cases.

108. The first case relied upon by the Council is the decision of Finlay P. (as he then was) in *M. v. the Medical Council* [1984] I.R. 485. The passage from that decision cited in support of the Council's argument reads as follows (at p. 494):

> "…On completion of the inquiry, the Committee report to the Council specifying the nature of the application, the evidence given before them and any other matters in relation to the registered medical practitioner which they may think fit to report as regards the alleged professional misconduct, and the fitness or otherwise of the practitioner to engage in the practice of medicine.
>
> Where the practitioner has been found by the Committee to be guilty of professional misconduct, or to be unfit to engage in the practice of medicine, the Council may decide that his name be erased from the register or that the registration of his name in the register should not have effect during a specified period: section 46.
>
> Following an inquiry and report by the Committee, and, apparently, irrespective of the precise findings of that inquiry and report the Council may:
>
> (a) attach such conditions as it thinks fit for the retention in the register of a person whose name is entered therein (s. 47) or,
>
> (b) advise, admonish or censure such person in relation to his professional misconduct: section 48.
>
> In the event of a decision by the Council under s. 46 of the Act of 1978 that the name of a person should be erased from the register, or that the effect of his registration should be suspended, that person may apply to the High Court within twenty-one days to cancel the decision and, upon such application, the High Court may either –
>
> (a) cancel the decision, or
>
> (b) direct the Council to erase that person's name from the register, or
>
> (c) direct that during a specified period the registration in the register shall not have effect.
>
> In the event of a decision by the Council under s. 47 to attach conditions to the retention of the registration of the person in the register, that person may apply within twenty-one days for the cancellation of that decision and the High Court on the application has jurisdiction:-
>
> (a) to cancel the decision, or
>
> (b) to direct the Council to attach such conditions as the court thinks fit to the retention of the name of the person in the register.

> In the event of a decision by the Council to advise, admonish or censure under s. 48, the practitioner has no right of application to the High Court."

109. For the most part this quotation is a recitation by the judge of the statutory provisions with little or no comment on them. The court was not called upon to consider the argument which is before me in this case. In fact s. 13(7) did not figure in the case at all. Accordingly, I find little, if anything, in this quotation or indeed any other aspects of the decision in *M. v. The Medical Council* which is of assistance.

110. The next case relied upon is the decision of Barrington J. in the Supreme Court in Barry v. The Medical Council [1998] 3 I.R. 368.

111. The principal passage cited from that decision is as follows:

> "From the foregoing it can be seen that disciplinary proceedings against a doctor which run the full course pass through at least three major phases. First, is the procedure before the Fitness to Practise Committee, second, is the procedure before the Council and third, is the procedure before the High Court.
>
> In the first phase, all the Fitness to Practise Committee can do is to hold an inquiry, make findings of fact and possibly make recommendations. In the second phase the Council may decide that the doctor should be removed from the register but it cannot remove him from the register itself. In the third phase, either the doctor can apply to the High Court for cancellation of the Council's decision or, if the doctor makes no such application within twenty-one days from the date of the said decision, the Council may apply ex parte for confirmation of its decision."

112. Again in this case neither this court nor the Supreme Court was asked to consider arguments of the type that I am dealing with here. The passage quoted contains a broad description of the three-fold nature of disciplinary proceedings that can be taken against a registered medical practitioner. Those statements are not inconsistent with what is argued on behalf of the applicants in this case. It is of course true that Barrington J. says that "in the second phase the Council may decide that the doctor should be removed from the register but it cannot remove him from the register itself". That might suggest that the court decided that the sole power of the Council in the second phase was to decide on the question of penalty. But the judge was not asked to and did not purport to deal with an argument based on the provisions of s. 13(7). I do not, therefore, read his decision as touching upon the point that I am called upon to deal with here.

113. The third decision relied on is my own in *Casey v. The Medical Council* [1999] 2 I.R. 534. In that case I had to consider an argument which was made to the effect that by imposing conditions or admonishing a practitioner under the provisions of ss. 47 and 48 of the Act in circumstances where there had been no finding of professional misconduct, the Council was in effect reversing decisions of the FPC. The passage quoted from my judgment is as follows:

> "There remains to be dealt with the contention that by utilising s. 47 and 48 the Council is effectively reversing the finding of the Committee which in the instant case was favourable to the applicant. I cannot accept that there is any validity in this view. The finding of the Committee on the complaint made against the applicant stands. The case was not made out against him and the finding is in his favour. Nothing that the Medical Council or this Court can do on an application by either side under s. 47 can alter that situation There is, therefore, no element of double jeopardy such as was contended for on behalf of the applicant."

114. Once again the quotation has to be seen in the context of the matter which was at issue in *Casey's* case. The case did not involve a consideration of s. 13(7) or the relationship between the Council and the FPC in that context.

115. In my opinion none of the cases cited deal with the point in issue. I am not convinced that they support the arguments made by the Council for the extremely limited role which its contends for itself in dealing with findings of the FPC.

116. The effect of the Council's approach results in the following. A medical practitioner found guilty by the narrowest of margins of professional misconduct by the FPC but who does not have a sanction imposed which attracts recourse to this Court under ss. 45 or 46 of the Act, can never again have the merits of his case considered in any form either by the Council or this Court. The Council is, on its own argument, precluded from so doing and the only jurisdiction which this Court can exercise is by way of judicial review. Judicial review is concerned with the decision making process and not the decision on its merits.

117. Whilst I do not wish in any way to trespass upon the case which lies in reserve should this aspect of the applicants challenge fail, it seems to me that such a result is certainly open to challenge by reference to the provisions of Article 40 of the Constitution and Article 6 of the Convention.

118. Insofar as it may be said that there is an ambiguity surrounding the inter relationship between s. 13(7) and s. 45(2), I ought to construe the Act in a manner which is consistent with constitutional norms.

119. In *McDonald v. Bord na gCon (No. 2)* [1965] I.R. 217 Walsh J. said of the presumption of constitutionality (which the Act enjoys) as follows:

> "One practical effect of this presumption is that if in respect of any provision or provisions of the Act, two or more constructions are reasonably open, one of which is constitutional and the other or others are unconstitutional, it must be presumed that the Oireachtas intended only the constitutional construction and the court called upon to adjudicate upon the constitutionality of the statutory provision should uphold the constitutional construction. It is only when there is no construction reasonably open which is not repugnant to the Constitution that the provision should be held to be repugnant".

120. Whilst I am not (at this juncture in any event) adjudicating upon the constitutionality of the Act nonetheless the dictum is helpful in analysing the Council's arguments.

121. A construction of the statutory provisions which renders the solemnly assembled Council impotent to consider and, if appropriate, refuse to confirm, a decision of the FPC on the most important decision affecting a doctors career, in circumstances where no appeal on the merits to this court is provided by the Act, is one which ought not to be preferred to the alternative construction urged by the applicants.

122. The alternative construction results in a report of the FPC being capable of review by the Council which is the body charged by the Act with the control of persons engaged in the practise of medicine. This alternative construction means that a doctor charged and found guilty of professional misconduct by the FPC is not deprived of having his case and that decision considered by the Council. Given the huge importance to any doctors career of a finding of professional misconduct, the alternative construction is, in my view, much more conducive to enjoyment of the rights conferred under the Constitution and the Convention. A decision of the FPC ought to be capable of independent reconsideration by the Council and, in my view, the Act so ordains.

123. It is, I think, of significance that the Council has never utilised the provisions of s. 13(7) to dispense with the necessity of confirmation of a decision of the FPC. If it had done, the exercise of that power would in circumstances such as the present case, leave itself open to challenge on constitutional and Convention grounds.

124. It follows that the Council in the present case was wrong in law in regarding itself as being bound by the decision of the FPC on the applicants guilt and confining itself solely to the question of penalty. By so doing the applicants were denied the opportunity of having the arguments addressed on their behalf considered in accordance with due process. The Council acted *ultra vires* in behaving as it did. Its decisions cannot stand and will be quashed.

125. It also follows that the advice proffered to the Council by its Registrar and in-house advisor was wrong in law. Such being so, it is not strictly necessary for me to consider the procedure that was adopted by the Council which led to that advice being given. Nonetheless, I think I ought to deal with it since it raises issues of some importance which may affect future cases. I ought also to deal with the other criticism made as to the Council's composition on the 6th February, 2007. I will deal with this topic first.

Composition of the Council

126. The twenty-two members of the Council who sat on the 6th February, 2007 included the five members who constituted the FPC which made the findings against the applicants. Had the Council not been wrongly advised as to its role, they would have been deciding on whether or not to confirm their own findings. As it was, they did have to decide on whether or not to follow their own recommendations on sanction. In the event, no disadvantage occurred to the applicants, because the FPC recommendations on sanction were not accepted by the Council. It is of course a matter of conjecture as to whether a similar result might have followed had the Council properly considered the FPC report on the question of misconduct.

127. Whether considering the FPC report on the question of liability or sanction it was in my view wrong that members of the FPC should have participated in the work of the Council on that occasion. The involvement involved a breach of the *nemo iudex in causa sua* rule.

128. That rule is of fundamental importance in bodies exercising judicial and quasi judicial roles. It was in my view objectionable that members of the FPC should have sat as members of the Council to consider their own report on the conduct of the applicants. Gone are the days when it was considered permissible that a decision maker exercising judicial or quasi judicial functions should sit with an appellate or confirming body to hear an appeal or confirmation against his own decision. It was not unusual for that to occur, even in the judicial sphere, in the nineteenth century. However, s. 24 of the Courts of Justice Act, 1924 prohibits a judge who heard a case from sitting as a member of the court of appeal when the case over which he presided is being considered. That statutory prohibition is no more than a statement of what is now considered to be a practical application of one of the two rules of natural justice.

129. A good example of the application of this rule is to be found in the case of *R (Snaith) v. Ulster Polytechnic* [1981] N.I. 28 where the applicant's dismissal was quashed because the members of the committee who had taken the initial decision to dismiss sat with the governors of the college when the appeal was heard.

Procedures of the Council

130. When the applicants case was before the FPC, the Registrar instructed counsel to present the Council's case. The applicants were represented by counsel and the FPC was advised by its own legal assessor. The procedure before the Council was fundamentally different. There was no independent legal assessor or advisor and such advice as was given was provided by the Registrar (who had instructed counsel in the presentation of the case against the applicants before the FPC) and the in house lawyer. Was it appropriate the legal advice should be furnished to the Council by the Registrar given the role played by him before the FPC?

131. Issue was also taken by the applicants as to the way in which this advice was tendered. Information on that is to be found at para. 44 of Dr. Hillery's affidavit, which I have already reproduced. There he acknowledges that the applicant's counsel argued that the Council could (and indeed ought to) reject the findings of the FPC. That submission was apparently discussed by the members of the Council. Then Dr. Hillery together with the Vice President took advice from the Registrar and Mr. William Kennedy. The carefully drafted paragraph is rather opaque as to the terms of the advice given. It is however clear that the advice furnished and followed was that consideration ought not to be given to the submissions made seeking a rejection of the FPC's report on the question of professional misconduct. The view was that such was not a function of the Council. Indeed the whole thrust of the Council's argument before me was to that effect.

132. The advice given to the President and Vice President was then apparently conveyed by them to the other Council members who had reconvened and, following further discussion, it was decided to impose no sanction.

133. The applicants argue that all of this was irregular. The advice was provided in circumstances unknown to the applicants and where they had no opportunity of addressing through their legal advisors the correctness or otherwise of the advice tendered. It is said that this amounts to a denial of *audi alteram partem* since the Council here relied upon information obtained outside the formal hearing without disclosing it to the party adversely affected by it. It is said that what occurred is all the more offensive because of the apparent delegation by the Council to its President and Vice-President of the task of taking that advice which was then communicated to the other Council members. No form of delegation is provided for in the 1978 Act. No information has been provided as to precisely what was said to the other Council members by the President or Vice-President.

Natural Justice

134. There is no fixed standard of natural justice which is applicable in all circumstances. The standard is plastic. It varies in accordance with the circumstances. As was said by Keane J. in *Mooney v. An Post* [1994] E.L.R. 103:

> "… the concept (of natural justice) is necessarily an imprecise one and what its application requires may differ significantly from case to case. The two great central principles – *audi alteram partem* and *nemo iudex in causa sua* – cannot be applied in a uniform fashion to every set of facts."

135. The standard to be applied to a person whose conduct is under investigation therefore varies according to the circumstances. In

the present case I am satisfied the high standards of natural justice must apply. The allegations made against the applicants were very serious and their whole professional standing was at stake. The applicants were entitled to expect that there would be strict adherence to the rules of natural justice and that justice would not only be done but be seen to be done in their dealings with the Council.

136. It was inappropriate that legal advice be tendered by the very officer who presented the case against the applicants before the FPC. I cannot see how such advice can be seen to be objective. I am not saying that the advice was in fact biased but there is the perception of bias arising from the role played by the advice giver when the cases where before the FPC.

137. Secondly, it was in my view quite wrong that the legal advice such as it was, was tendered only to the President and Vice President of the Council. If there was an entitlement on the part of the Council to legal advice, it should have been furnished to all and at the same time. It was not good enough that the verbal advice furnished to the President and Vice President should be retailed by them to the other members of the Council.

138. Thirdly, the method of receiving the advice was in my view deficient. It was a form of denial of the *audi alteram* rule because it enabled the Council to rely upon information obtained outside the hearing and not disclosed to the applicants who were adversely affected by it. The decided case which, in my view, most closely approximates to what occurred here is that of *The State (Polymark Limited) v. ITGWU* [1987] I.L.R.M. 357.

139. In that case the employer made a submission before the Labour Court to the effect that it had no jurisdiction to entertain an appeal from an equality officer. The Labour Court adjourned the case in order to seek legal advice from its Registrar. Having received it, it continued with the case. In the High Court, the employer complained that his counsel in the Labour Court had not been made aware of the advice given or afforded an opportunity of commenting upon it. Blayney J. took the view that even if this were correct he ought to exercise his discretion against granting relief since no useful purpose would be served by so doing. However, the judge was clearly of the view that the complaint made was correct in law and provided a rubric, which might be followed in the future. He said:

> "It might be of assistance for the future, however, if I were to indicate what procedure the Labour Court could safely adopt if similar circumstances arise again. They should first inform the parties of their intention to ask the Registrar for legal advice; then having obtained the advice, they should, at a resumed hearing, inform the parties of the nature of the advice they had obtained and give the parties an opportunity of making submissions in regard to it, and finally, having heard the submissions, the members of the court should, on their own, without further reference to the Registrar, arrive at their own conclusion on the issue."

140. I am conscious of the reliance which is placed by the Council on the later decision of Murphy J. as affirmed by the Supreme Court in *Georgopolous v. Beaumont Hospital Board* ([1994] 1 I.L.R.M. 58 and (Unreported, Supreme Court, 4th June, 1997)). I do not read the decision of either Murphy J. in the High Court or Hamilton C.J. in the Supreme Court as casting any doubt on the legal soundness of the observations of Blayney J. which I have just quoted. On the contrary, Murphy J. expressly agrees with the observations where he says:

> "I would respectfully agree with what Blayney J. was quoted as saying in that judgment. It seems to me that his views were based on the practice traditionally adopted by judges of the High Court of repeating for the benefit of counsel any advice, information or observation given to him by a Registrar of the court.... However, in the present case it is essential to bear in mind that the function of the Board was to determine as a matter of fact whether the allegations made against their employee were well-founded. They were not determining any question of law nor would they have been competent to do so. The need for legal guidance was to ensure that a lay body was acquainted with what may be seen as the ever-expanding requirements of the rules of natural and constitutional justice. …Indeed one might expect something in the nature of a conference or informal seminar to brief the members of such a tribunal on the legal principles applicable to their functions. It seems to me inconceivable that a tribunal having obtained. … such advice should be required to lay it before any parties … pleading before them."

141. In the *Georgopolous* case the plaintiff had been employed as a doctor by the hospital. The hospital board held an oral hearing for the purposes of enquiring into complaints that had been made about him. Both parties were legally represented. During the hearing the hospital board received supplementary legal advice concerning procedure from a retired judge who sat with it. The advice was not disclosed to the plaintiff.

142. On appeal, Hamilton C.J., again appeared to accept the correctness of the views of Blayney J. but distinguished the *Polymark* case on the basis that the issue between the parties in *Polymark* was purely a question of law relating to the jurisdiction of the Labour Court, whereas the function of the Beaumont Hospital Board was to determine as a matter of fact, whether allegations made against the plaintiff were well founded. The authors of the 3rd Edition of *Administrative Law in Ireland*, describe this distinguishing as being rather unconvincing. Whether that be so or not (and I tend to agree with them) I am quite satisfied that on the facts, the *Polymark* case is much closer to what I am concerned with here.

143. I am also satisfied that the view which I take is consistent with a line of authority in England on the same topic.

144. In *Nwabueze v. General Medical Council* [2000] 1 W.L.R. 1760, the legal assessor to the Professional Conduct Committee of the General Medical Council gave that committee advice during its retirement. On the committee's return, the assessor informed the parties what that advice had been. Without the parties having been given an opportunity to comment on the advice the chairman announced the decision of the committee. Lord Hope of Craighead, giving the opinion of the Privy Council, said:

> "... The principle which lies behind the requirement that the party should be informed of the assessor's advice to the committee is that of fairness, and that fairness requires that the party should be afforded an opportunity to comment on that advice and that the committee should have an opportunity to consider their comments before announcing their determination. The transcript of the proceedings indicates that the chairman regarded the legal assessor's statement about the legal advice which he had tendered to the committee while they were deliberating in camera as a mere formality, as the committee had already arrived at their determination which he was about to announce. This was a misconception, as the reason why the legal assessor's advice to the committee must be given or made known to the parties afterwards in public, is so that the parties may have an opportunity of correcting it or asking it to be supplemented as the circumstances may require. In this respect, the requirements of the common law would appear to be at one with those of Article 6 of the Convention."

145. That decision has been applied more recently in *Watson v. General Medical Council* [2005] E.W.H.C. 1896. There, Stanley Burnton J. in the High Court quashed the determination of the Fitness to Practice Panel of the General Medical Council because the appellant's counsel was not given an opportunity to address the panel on the substance of the medical assessor's advice. The judge in considering the procedure followed in the context of Article 6 of the Convention followed *Nwabueze's* case and held that the parties must be given an opportunity to make representations on legal advice given by a legal assessor to a disciplinary tribunal. Indeed he went further where he said:

> "In my judgment the authorities to which I have referred above establish that those who advise a tribunal on issues of fact whether as its experts or assessors, should do so openly, in the presence of the parties, and in circumstances in which the parties have an opportunity to make submissions on that advice before the Tribunal makes its decision. That is, in general what fairness requires."

146. In my view, the procedure followed in the present case was defective. Even if the correct advice as to jurisdiction had been given the procedure followed would warrant the decision of the Council being quashed.

147. As Blayney J. did in the *Polymark* case, I believe that I ought to indicate how the Council should in the future deal with reports of the FPC.

148. The Council should not have members of the FPC who conducted the hearing and prepared the report under consideration sitting when a s.13(7) meeting is taking place. The Council should hear and consider any relevant submissions from the doctor concerned and the Registrar. If it wishes to obtain legal advice it should obtain it from an independent lawyer (as the FPC does). The procedure outlined by Blayney J. in the *Polymark* case ought to be followed in respect of that advice. Having done so (if such advice was necessary) the Council should then decide whether or not to confirm the FPC report both as to guilt and sanction.

Absence of Reasons – The Council
149. The decision of the Council is also criticised because of the absence of reasons given by it for concluding that no sanction ought to be imposed. It is said that if it was the case that no sanction was imposed because a majority of the Council did not consider the applicants to have been guilty of misconduct then that was a relevant fact which the applicants were entitled to know.

150. I do not propose to address this criticism, as it is not necessary for me to do so. Rather I will have some observations to make about the absence of reasons when I consider the findings of the FPC. A similar criticism is made of it.

Council Decision
151. As is apparent, the decision of the Council cannot stand and *certiorari* will go to quash it. The Council contends that I ought to remit the matter back to it so that it may reconsider the report of the FPC in the light of the findings which I have made. There would be something to be said for that argument if the decision of the FPC itself is not legally invalid. The applicants contend that it is for three reasons. First, they say that the FPC and indeed the Council applied an incorrect standard of professional misconduct. Secondly, they say that the report of the FPC is flawed by virtue of its failure to give reasons for the conclusions which it reached. Thirdly, they say that the decision arrived at was unreasonable in the legal sense of that term which is applied on judicial review. If the applicants succeed on some or all of these grounds then the report of the FPC itself will be at risk of being struck down.

152. I propose to deal with the complaint concerning the wrongful standard of professional misconduct first.

Professional Misconduct
153. Professor Prendiville was found guilty by a majority of the FPC of professional misconduct in the respect of one of the twelve allegations made against him. That allegation was that he

> "Stated in the said report that there was no evidence of questionable clinical judgment or faulty decision making on the part of Dr. Neary in circumstances where there was such evidence in the material available to him".

154. The three allegations in respect of which Dr. Murphy was found guilty were that he

> "8. Stated in the said report that Dr. Neary had no case to answer in respect of the cases reviewed in the said report when this was not a conclusion that could be legitimately expressed without also expressing serious reservations about some or all of the cases, and/or
>
> 9. Stated in the said report that Dr. Neary should continue to work in Our Lady of Lourdes Hospital without any restrictions on his practice in circumstances where he knew or ought to have know there were grounds for placing restriction on Dr. Neary's practice.
>
> 10. Stated that Dr. Neary should continue to work in Our Lady of Lourdes Hospital without any restriction on his practice in circumstances where that conclusion could not legitimately be expressed without also expressing serious reservations in that regard."

155. In the case of each of the doctors, the FPC in making its findings did so on the basis that the allegations, which had been proved, amounted

> "To professional misconduct as defined by Keane J. in *O'Laoire v. The Medical Council* being conduct in connection with his profession in which the medical practitioner has seriously fallen short of the standards of conduct expected among medical practitioners, and not in a sense of any "infamous" or "disgraceful" conduct or any conduct involving any degree of moral turpitude, fraud or dishonesty."

156. Throughout the hearing this definition was described as the 'expected standards of conduct' test.

157. There is another standard of professional conduct which was referred to as the 'moral turpitude' standard. It can be defined as 'conduct which doctors of experience, competence and of good repute consider disgraceful of dishonourable'.

158. It was submitted to the FPC that it was the 'moral turpitude' rather than 'expected standards test' that they ought to apply in considering the allegations made against the applicants.

159. It is common case that the Council has from time to time issued a guide to ethical conduct and behaviour for members of the

medical profession. Such guides have been issued pursuant to the requirements of s. 69(2) of the Act. This section provides:

> "It shall be a function of the Council to give guidance to the medical profession generally on all matters relating to ethical conduct and behaviour".

160. In 1998 the Council issued the fifth edition of this guide. The guide is some forty eight pages in length dealing *inter alia* with conduct and behaviour, doctors and patients, professional responsibilities, doctors in practice and confidentiality and consent.

161. In section A of the guide, which deals with conduct and behaviour, professional misconduct is described at para. 1.5. The definition is as follows:

> "Professional misconduct is conduct which doctors of experience, competence and good repute, upholding the fundamental aims of the profession, consider disgraceful or dishonourable".

162. It is a perfect articulation of the 'moral turpitude' standard.

163. It is also common case that it was this fifth edition of the guide, which was in force during the time of the allegations of wrongdoing made against the applicants.

164. The sixth edition of the guide was published in 2004. In this edition, the definition of professional misconduct is different. It reads (again at para. 1.5) that professional misconduct is

> "(a) conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable; and/or (b) conduct connected with his or her profession in which the doctor concerned has seriously fallen short by omission or commission of the standards of conduct expected among doctors".

165. Paragraph (b) is a perfect articulation of the 'expected standards' test.

166. It is clear that the FPC in making its findings, did so by reference to the decision of Keane J. in *O'Laoire v. The Medical Council* (Unreported, 27th January, 1995).

167. As the FPC relied upon this judgment to make its findings against the applicants, it is necessary to look at it in some little detail.

The Decision in O'Laoire's case

168. The judgment of Keane J. (as he then was) is masterly and comprehensive. It runs to some 387 pages including appendices. From page 99 to 108, he deals with the meaning of professional misconduct. He points out that the term is not defined in the Act. He says that its meaning, and that of corresponding expressions which appeared in earlier legislation, has been considered in a number of authorities in Ireland and England. He begins his review of those authorities by reference to the decision of Kenny J. in *Re Lynch & Daly* [1970] 1 I.R.

169. He points out that in 1983 in the relevant legislation affecting dentists in England, the expression 'infamous or disgraceful conduct in a professional respect' was replaced by the expression 'serious professional misconduct'. He recalls that that same legislation provided that a significantly less severe penalty than striking off the register could be imposed when such a finding of misconduct was made. i.e. suspension for a period not exceeding twelve months. He cites from the decision of Lord Mackay in *Doughty v. General Dental Council* [1987] 3 All E.R. 843. In that case it was held that while the findings against the appellant did not import any moral stigma, they were of a nature which the committee was entitled to hold rendered it right for it to direct the striking off of the appellant.

170. Having reviewed the authorities Keane J. deduced the following principles:

> "1. Conduct which is 'infamous' or 'disgraceful' in a professional respect is 'professional misconduct' within the meaning of s. 46(1) of the Act.
>
> 2. Conduct which would not be 'infamous' or 'disgraceful' in any other person, if done by a medical practitioner in relation to his profession, that is, with regard to either his patients or to his colleagues, may be considered as 'infamous' or 'disgraceful' conduct in a professional respect.
>
> 3. 'Infamous' or 'disgraceful' conduct is conduct involving some degree of moral turpitude, fraud or dishonesty.
>
> 4. The fact that a person wrongly but honestly forms a particular opinion cannot of itself amount to infamous or disgraceful conduct in a professional sense.
>
> 5. 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."

171. The judge went on:-

> "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.
>
> In considering how these principles should be applied to the facts of the present case, the standards applicable in the medical profession in this country, as laid down in official publications and discussed by various witnesses, are clearly of importance and are considered in more detail in a later section of this judgment. It should, however, be pointed out at this stage that s. 69 (2) of the Act provides that "it shall be a function of the Council to give guidance to the medical profession generally on all matters relating to ethical conduct and behaviour."
>
> The guide to Ethical Conduct and Behaviour and to Fitness to Practice (third edition, 1989) issued by the Council defines

professional misconduct as:-

> "conduct which doctors of experience, competence and of good repute, consider disgraceful or dishonourable".

The principle at 5 above should be seen as modified in the light of that statement. Finally, section 46 (9) of the Act provides that:-

> "on the hearing of an application under this section, the High Court may, if it thinks proper to do so, admit and have regard to evidence of any person of standing in the medical profession as to what is professional misconduct." (Emphasis mine)

172. It seems clear from the above quotation that whilst Keane J. identified five principles which he deduced by reference to Irish and English case law, the fifth of those principles, in his view, fell to be modified by virtue of the definition of professional misconduct as contained in the third edition of the Council's guide. The wording of the fifth edition of the guide differs from the third edition in that it interposes the phrase "upholding the fundamental aims of the profession" before the words "consider disgraceful of dishonourable". Nothing turns on this.

173. The fifth edition of the guide post dated the judgment in *O'Laoire's* case by about three years. It was not until the sixth edition of the guide in 2004 that the "expected standards" test was published by the Council. There can be no doubt, having regard to the wording of the sixth edition of the guide, that from the time of its publication the 'expected standards' test is applicable in relation to professional misconduct on the part of the members of the medical profession.

174. The applicants argue that that test was not appropriate to be applied in relation to the allegations made against them. They say that whilst Keane J. identified the 'expected standards' test at number 5 in the principles identified by him from a consideration of (mostly English) case law, he made it clear that it had to be modified in the light of the Council's guide then in force.

175. The Council argue that the "expected standards" test was the appropriate test by which to judge the applicants' conduct. They contend that the changes introduced by the Act were similar to those brought about five years later by the Dentists Act of 1983 in England, which in turn was considered in *Doughty v. General Dental Council*. By reference to that decision the Council contends that the "expected standards" test was in effect as and from the coming into force of the Act of 1978.

176. If that be so, it is astonishing that in the five editions of the guide published by the Council between its creation in 1978 and the year 2004, nowhere in the definition of professional misconduct is the 'expected standards' test mentioned. It is not until the publication of the sixth edition in 2004, that it is to be found.

177. The Council argues that the guide is no more than that. To suggest that professional misconduct can only be viewed in the light of the provisions of the guide is to elevate its provisions into legislation, which, it is argued, would repeal the express provisions of the Act of 1978. This would in turn put at nought the intent of the legislature in enacting the Act and would fly in the face of the decision in *Doughty*.

178. If all that be correct, then why did Keane J. in *O'Laoire's* case make it perfectly plain that the fifth principle identified by him had to be modified in the light of the definition of professional misconduct contained in the third edition of the guide?

179. *Doughty's* case postdates the Act as indeed does the (English) Dentists Act of 1983. It was *Doughty's* case which introduced the 'expected standards' test and applied it, notwithstanding the fact that the Medical Council in its guide of April 1985 had said that the substitution of the expression "serious professional misconduct" for the phrase "infamous conduct in a professional respect" was intended to have the same meaning and significance. The Council argued that that same rationale should apply here, and that the 'expected standards' test has been appropriate since the coming into force of the Act, despite the fact that the test was not invented until the decision in *Doughty's* case many years later. If they are correct in this view, it seems to make nonsense of the sentence from the decision of Keane J. in *O'Laoire's* case to the effect that the fifth principle had to be seen as modified in the light of the statement in the Council's guide.

180. I accept that the guide published by the Council is no more than that, namely a guide. It is however published pursuant to the provisions of s. 69(2) of the Act, which imposes a function on the Council to give guidance to the medical profession generally on all matters relating to ethical conduct and behaviour. It is not too much to expect that a doctor on consulting the guide would at least be apprised in general terms of what the Council understands professional misconduct to mean. Of course, one is not entitled to look for absolute precision in a guide. The notion of professional misconduct can change from time to time because of changing circumstances and new eventualities. It would be unreasonable to expect the Council to publish a catalogue of the forms of professional misconduct which may lead to disciplinary action. But if a new test is to be applied or a new species of conduct is to be regarded as amounting to professional misconduct, then one would expect the Council to notify its members of that. Indeed, that is precisely what it did by the publication of the sixth edition of the guide in 2004. There would have been no need to do so if the Council's argument here is correct.

181. The statement of Keane J. in *O'Laoire's* case which I have quoted contained an implicit invitation to the Council to alter the definition of professional misconduct if it so wished. It is the Council and not the Court that is charged by statute with the registration and control of medical practitioners. The invitation was accepted, but not until 2004, when the sixth edition of the guide was published.

182. Reliance was placed upon the words of Lord Clyde in *Roylance v. General Medical Council* [2000] A.C. 311, where he said:

> "The expression 'serious professional misconduct' is not defined in the legislation and it is inappropriate to attempt any exhaustive definition. It is the successor of the earlier phrase used in the Medical Act, 1858, 'infamous conduct in a professional respect', but it was not suggested that any real difference of meaning is intended by the change of words. This is not an area in which an absolute precision can be looked for. The booklet which the General Medical Council have prepared 'professional conduct and discipline; fitness to practice' (December, 1993), indeed recognises the impossibility in changing circumstances and new eventualities of prescribing a complete catalogue of the forms of professional misconduct which may lead to disciplinary action. Council for the doctor argued that there must be some certainty in the definition so that it can be known in advance what conduct will, and what will not qualify as serious professional misconduct. But while many examples can be given the list cannot be regarded as exhaustive. Moreover, the professional misconduct committee are well placed in the light of their own experience, whether lay or professional, to decide where

precisely the line falls to be drawn in the circumstances of particular cases, and their skill and knowledge requires to be respected. However, the essential elements of the concept can be identified."

183. I have already accepted the impossibility of cataloguing what may amount to professional misconduct. But, to use the last sentence from the passage quoted, the essential elements of the concept can be identified. The Council did not identify the 'expected standards' test until the publication of the sixth edition of its guide. The standard ought not therefore to have, in my view, been applied prior to the Council making its position clear on the matter.

184. It is to be noticed that in *O'Laoire's* case, although Keane J. identified the 'expected standards' test and went on to say that it should be seen as modified in the light of the definition of professional misconduct in the third edition of the guide, he found Mr O'Laoire guilty of conduct which was disgraceful and dishonourable. He does not appear to have applied the 'expected standards' test to Mr O'Laoire. This is entirely consistent with his acknowledgement that it had to be modified by reference to what was stated in the guide.

185. The Council also rely on a series of decisions of this Court, in particular those of O'Donovan J. in *Perez v. An Bord Altranais* [2004] 4 I.R. 298, of Hanna J. in *Moore v. The Medical Council* (Ex tempore, 19th December, 2006) and Charleton J. in *Barry v. The Medical Council* (Unreported, 2nd March, 2007).

186. All of these cases applied the 'expected standards' test and all of them did so by reference to the identification of that principle in the judgment of Keane J. in *O'Laoire's* case. None of the judges in question appear to have had their attention drawn to the subsequent dictum of Keane J. concerning the modification of that principle by reference to the guide. Indeed it has to be said that the question was not in issue in those cases. Nobody appears to have adverted to the topic.

187. In the present case it appears clear that the FPC applied the 'expected standards' test by reference to the judgment of Keane J. in *O'Laoire's* case without any account being taken of the modification. In my view, they were not entitled so to do, and it is unreasonable and unfair to expect medical practitioners to be subjected to a test of professional misconduct, which the Council had not promulgated or notified to the profession until years after the event.

Absence of Reasons – the FPC

188. The decision of the Council in suit was communicated to the applicants by letters of 7th February, 2007. The letter to Professor Prendiville, having made reference to the findings of the FPC, then stated:

> "The Council took careful note of the submission which was made on your behalf in reaching its decision on the question of whether or not a sanction should be imposed. The Council has instructed me to inform you that it has decided not to impose any sanction on you in relation to your professional conduct, notwithstanding the findings of the Fitness to Practise Committee that the facts set out at allegations 1, 3, 5, 9, 10 and 11 in the Notice of Enquiry were proved and that allegation 9, as proved, does amount to professional misconduct. The decision was made by the Council at its meeting on February 6th, 2007."

189. A similar letter was sent to Dr. Murphy with necessary modifications to reflect the findings of the FPC. These communications are criticised because they do not provide any reasons for the decision to confirm the findings of the FPC. That is hardly surprising since the Council took the view that it had no option but to confirm them.

190. Criticism is also levelled at the Council for not stating any reasons for deciding why no sanction ought to be imposed. As I have said I do not propose to deal with this complaint since no prejudice was suffered by the applicants arising out of this.

191. A similar criticism is levelled against the FPC. Appendix 6 contains the FPC report in full. It is eight pages long. Six of the pages are devoted to a recital of the identity of the parties to the enquiry and the dates on which it sat, a recitation that the criminal standard of proof was to be applied by the FPC and a setting out of the allegations made against each of the applicants, and Dr. Stuart. It is only in the final two pages that the FPC deals with its decision. The decision is set out in the tersest form possible. In the case of Dr. Murphy, it says as follows:

> "Dr. Murphy
>
> Having heard the evidence adduced the committee finds, by a majority, allegations 1, 3, 5, 8, 9 and 10 proved."

192. In the case of Professor Prendiville, it says:

> "Having heard the evidence adduced the committee finds, by a majority, allegations 1, 3, 5, 9, 10 and 11 proved."

193. It then goes on to say under the heading "professional misconduct" in the case of Dr. Murphy:

> "The committee finds that allegations 1, 3 and 5, as proved, do not amount to professional misconduct and by a majority that allegations 8, 9 and 10, as proved, do amount to professional misconduct as defined by Keane J. in *O'Laoire v. The Medical Council*, being conduct in connection with his profession in which the medical practitioner has seriously fallen short of the standards of conduct expected among medical practitioners and not in a sense of any 'infamous' or 'disgraceful' conduct or any conduct involving any degree of moral turpitude, fraud or dishonesty."

194. The finding against Professor Prendiville is in precisely the same terms, save that the finding is in respect of allegations 1, 3, 5, 10 and 11 as having been proved but not amounting to professional misconduct and, by a majority, that allegation 9 does amount to professional misconduct. The report then contains the recommendations to the Council. It recommended admonishment in the case of Dr. Murphy and advice being given to Professor Prendiville, although the report mistakenly refers to him as Dr. Stuart.

195. There appears to be no consistency of practice on the part of the FPC as to the form of its reports to the Council. There is no dispute but that in, for example, the case of the FPC report on Dr. Neary himself, the document ran to in excess of one hundred pages, and clearly was a reasoned one.

196. The report in the instant case is more in the nature of an issue paper containing findings rather than a reasoned judgment.

197. The Council contends that there is no duty to give reasons on the part of the FPC. It does so by reference to the decision of Costello P. in *McCormack v. Garda Complaints Board* [1997] 2 I.R. 389 and a series of Privy Council decisions beginning with *Libman*

v. GMC [1972] 1 A.C. 217, *Rai v. GMC* (Unreported, Lord Scarman, 14th May, 1984) and *Gupta v. GMC* [2002] 1 W.L.R 1691.

198. In McCormack's case Costello P. said:

> "The rules of natural justice are rules of the common law which are applied in our courts when considering the validity of administrative decisions. It is well established by the courts in England that the rules of natural justice do not require that reasons should be given for administrative decisions (*R v. The Gaming Board* [1970] 2 Q.B. 417), and in England it was considered necessary for parliament to step in and to require that 'tribunals' (as defined) should be required to do so (Tribunals and Enquiries Act, 1971), whilst in Australia (another common law country) the federal parliament went further and enacted that this principle should be extended to administrative decisions generally (Administrative Decisions (Judicial Review) Act, 1997).
>
> In this country, the Oireachtas has remained inactive in this field. In theory our courts would be free to extend the common law principles of natural justice as they are judge- made rules but it would seem preferable that the existence, scope and nature of the duty to provide reasons for an administrative decision should be considered in the light of the constitutional requirement relating to what the courts have termed "constitutional justice", rather than as an extension of the common law rules of natural justice… It is not the law of this country that procedural fairness requires that in every case an administrative decision making authority must give reasons for its decisions."

199. In *Libman's* case Lord Hailsham said:

> "Beyond a bare statement of its findings of fact the Disciplinary Committee does not in general give reasons for its decision as in the case of a trial in the High Court by judge alone from which on appeal by way of rehearing lies to the Court of Appeal."

200. In *Rai's* case Lord Scarman said:

> "Though no obligation rests upon the Professional Conduct Committee to give reasons, in some cases where an acute conflict of evidence arises or where an important difference of opinion emerges, the committee may find it helpful to do so. Though there is no obligation, the committee has the power to give reasons: and their Lordships suggest that giving reasons can be beneficial and assist justice:-
>
> > (1) in a complex case to enable the doctor to understand the Committee's reasons for finding against him; …
> >
> > (3) because a reasoned finding can improve and strengthen the appeal process."

201. In the present case not merely were there important differences of opinion between the various witnesses who gave evidence before the FPC but that committee was itself split on the issues since the decision in suit was a majority one (though by what majority we are not told).

202. In *Gupta's* case the Privy Council was called upon to consider an earlier decision relied upon by the applicants called *Selvanathan v. GMC* [2001] Lloyds Rep Med 1. In *Gupta's* case the Privy Council held that there was no general duty on the Professional Conduct Committee of the GMC to give reasons for its decisions on matters of fact, particularly where its decision depended essentially on resolving questions of the credibility of witnesses. In the course of his opinion, Lord Rodger considered the earlier opinion of Lord Hope in *Selvanathan's* case. In that case Lord Hope had said:

> "It is not to be expected of the committee that they should give detailed reasons for their findings of fact. A general explanation of the basis for their determination on the questions of serious professional misconduct and of penalty will be sufficient in most cases. In the present case the complaint is that reasons should have been given to explain the basis upon which the committee found against the appellant on the questions of fact raised by head 2(b). It was plain, however, from the outset that their decision on this point was going to depend upon inferences which it was open to them to make from agreed facts and on the committee's assessment of the appellants credibility. The issue was a relatively simple one, and all the appellant needed to know in order to decide what to do next was the decision which the committee had reached upon it. There are no grounds for thinking that the appellant has suffered any prejudice due to the absence of reasons directed specifically to this finding. In these circumstances their Lordships do not consider that it was necessary for reasons for this part of the committee's decision to be given."

203. Lord Rodger said of that passage:

> "In that passage their Lordships affirmed the existence of the duty to give a general explanation for the committee's decisions on questions of serious professional misconduct and of penalty. By contrast, they rejected the existence of any such duty to give reasons for the committee decision on the matters of fact in that case."

204. I do not read the decision in *Gupta* as absolving a committee such as the FPC from the obligation to give a general explanation of the basis for its determination on questions of serious professional misconduct. Without trespassing into a detailed consideration of the evidence which was given to the FPC, I do not think that the present case can be characterised as one involving only questions of fact, still less the credibility of witnesses.

205. I am of the opinion that the applicants were entitled to at least a general explanation of the basis for the majority decision of the FPC. I do not believe that what they obtained in the present case was such. I have already referred to the inconsistency in practice on the part of the FPC in this regard.

206. I believe that my views are in accordance with authorities in this jurisdiction dealing with the duty to give reasons. There is an ever-increasing body of case law on the topic, though I mention just some of the cases by way of illustration.

207. In *Rajah v. The Royal College of Surgeons of Ireland* [1994] 1 I.R. 384, Keane J. said:

> "In general, bodies which are not courts but which exercise functions of a judicial or quasi judicial nature determining legal rights and obligations must give reasons for their decisions, because of the requirements of constitutional and natural justice and in order to ensure that the superior courts may exercise their jurisdiction to enquire into and, if necessary, correct such decisions: see *The (State) Creedon v. Criminal Injuries Compensation Tribunal*. The requirement to give

reasons may extend even further to purely administrative bodies, at least where their decisions affect legal rights and obligations… a decision such as that of the respondents in the present case, however, was not, in my view, of a nature which necessitated the giving of reasons."

208. More recently, the Supreme Court considered the topic in *F.P. v. The Minister for Justice* [2002] 1 I.R. 164. There Hardiman J. said:

> "This Court in *Ní Eili v. The Environmental Protection Agency* (Unreported, Supreme Court, 30th July, 1999) surveyed the authorities in some detail and inter alia cited with approval the decision of Evans L.J. in *MJT Securities v. Secretary for State for the Environment* [1998] J.P.L. 138.
>
> Dealing with statutory obligations to give reasons the trial judge said at p. 144 that:-
>
> > 'The Inspectors statutory obligation was to give reasons for his decision and the Courts can do no more than say the reasons must be proper intelligible and adequate as has been held. What degree of particularity is required must depend on the circumstances of each case…'
>
> In the case of administrative decisions, it has never been held that the decision maker is bound to provide a 'discursive judgment as a result of its deliberations'; see *O'Donohue v. An Bord Pleanála* [1991] I.L.R.M. 750 at p. 757.
>
> Moreover, it seems clear that the question of the degree to which a decision must be supported by reasons stated in detail will vary with the nature of the decision itself. In a case such as *International Fishing Vessels Ltd. v. Minister for Marine* [1989] I.R. 149 or *Dunnes Stores Ireland Company v. Maloney* [1999] 3 I.R. 542, there was a multiplicity of possible reasons, some capable of being unknown even in their general nature to the person affected. This situation may require a more ample statement of reasons than in a simpler case where the issues are more defined."

209. In my view, the FPC was obliged to give reasons for coming to the conclusion, which it did. It was not obliged to provide a discursive judgment, but I accept the applicants complaint that they were left "absolutely in the dark" as to the basis for the FPC's findings. That is all the more so in the circumstances where it is clear that, contrary to the requirements of s. 45 (3)(c), the report did not specify the evidence laid before the FPC.

210. A statement of the reasons for the FPC decision would have been essential so as to enable the Council to hear submissions and decide on whether or not it ought to confirm the FPC's findings. Even if I am wrong in the view which I take concerning the role of the Council, and it is in fact no more than a cypher for the FPC save on the question of sanction, the applicants are entitled to know the basis of the decision in the context of an application for judicial review. As was said by Keane J. reasons are necessary in order to ensure that the superior courts may exercise their jurisdiction to enquire into, and if necessary, correct such decisions.

211. In these circumstances, I am satisfied that the decision of the FPC is also deficient by reason of the lack of reasons given for its findings.

Irrationality

212. Counsel for the applicants and the Council both referred in considerable detail to parts of the evidence given to the FPC in order to demonstrate the unreasonableness or otherwise of the decision arrived at by it. Having regard to the other findings made by me, it is not necessary for me to explore this area. The task of attempting to do so was rendered very difficult by virtue of the absence of any reasons being given by the FPC for its decision. In the event it is not necessary to consider this topic since for all of the reasons already given the decision of the Council and FPC must be quashed.

Remission

213. It was submitted by the Council that in the event of the applicants being successful, the case ought to be remitted pursuant to provisions of order 84, rule 26(4) of the Rules of the Superior Courts, or the inherent jurisdiction of the court.

214. In *Usk and District Residents Association Limited v. An Bord Pleanála and Others* [2007] I.E.H.C. 86 I considered the discretionary jurisdiction of this Court to order remission and the exercise of that discretion.

215. As to the exercise of the discretion, I said:-

> "The discretion to remit proceedings is a wide one. There is not a lot of assistance to be gleaned from such case law as there is on the topic as to the factors to taken into account in the exercise of that discretion. Many of the cases deal with the remission of criminal cases to the District Court. Those which involve the remission of cases such as the present one deal with the topic in little more than a sentence. For example in *Hoborn Homes Limited v. An Bord Pleanála*, [1993] I.L.R.M. 368, Denham J. made an order remitting the matter back to the Planning Board. She dealt with in a single sentence in the judgment by observing that it was an appropriate case to do so. Similarly in *Aherne v. Kerry County Council*, [1998] I.L.R.M. 392, Blayney J. remitted a matter back to the local authority in like manner. In *Hurley v. Motor Insurers Bureau of Ireland*, [1993] I.L.R.M. 886, Carroll J. similarly referred the matter back to the Council of the M.I.B.I. in the final sentence of her judgment.
>
> The nearest one comes to any consideration of the topic is to be found in the judgment of Murray J. in *Nevin v. Crowley* [2001] I.R. 113. That was a case involving certiorari directed to a District Judge concerning a criminal conviction. In the course of his judgment Murray J. said:-
>
> > 'This Court, in *Sweeney v. Judge Brophy*, [1993] 2 I.R. 5202 at p. 201, held that the proper exercise of a Court's discretion in such a case 'would require that the matter should not be remitted to the District Court in circumstances where the applicant has endured enough and the prosecution cannot be acquitted of all the blame for some, at least, of what went wrong at the trial'.
> >
> > This is not to be considered an exhaustive list of relevant considerations concerning exercise of discretion which could include such matters as the passage of time, any period of imprisonment already served, whether the offence was a serious one or a minor one'.

These observations do not have much relevance in the context of civil proceedings such as I am dealing with here.

I think the best that can be said is that the exercise of the discretion is a wide one and it would be both impossible and unwise to attempt to set out in a comprehensive fashion all the factors, which the court ought to take into consideration. That will have to be developed on a case by case basis. The one thing that can be said is that the discretion must be exercised both judicially and judiciously with the overall object of achieving a just result."

These cases cited are merely illustrative of the wide discretion vested in the Court and some of the factors which ought to be taken into account.

216. In the present case the Court is quashing the decision of the Council and the FPC. If just the decision of the Council were being quashed, there might be something to be said for remittal to it. However, the decision of the FPC is also being quashed on a number of bases. In particular, it is my view, that the FPC was not entitled to apply the 'expected standards' test to the conduct complained of against the applicants. In these circumstances there would be no point in remitting the matter.

217. Even if I am wrong in that, I am quite satisfied that having regard to the passage of time since the events complained of, the number of years that disciplinary proceeding have been hanging over the applicants and the undoubted damage which has been done to them, it would be quite inequitable and unfair to remit the case.

Result
218. The decisions of the FPC and Council are quashed. The cases will not be remitted.

PRENDIVILLE

V

MEDICAL COUNCIL AND ORS

Appendix 1

To judgment of Mr. Justice Kelly

of

14th December, 2007

Preliminary report concerning the need for an investigation into the Obstetric practice of Michael Neary at Our Lady of Lourdes Hospital in Drogheda, with - particular reference to the rate of Caesarean Hysterectomy.
To Mr Finbarr Fitzpatrick, Secretary, IHCA

Following your telephone conversation of 3rd November 1998, we interviewed Dr Neary and reviewed provided photocopies of 17 charts of patients who had a caesarean hysterectomy in the years 1996 to 1998, in which cases the decision to perform a hysterectomy was taken by Dr Neary. By way of background information the following points were ascertained.
-
1. Dr Neary was appointed Consultant in .Ob/Gyn at the Lourdes Hospital in 1974. There has been a relatively high incidence of caesarean hysterectomy .in the Lourdes Hospital since 1961, 13 years before Dr Neary's appointment.

2. So far as the information is available, no patient has complained about the need for caesarean hysterectomy nor is any medico-legal action pending as a result of any of these cases. The complaints specified in the letter to Dr Neary of 24 October from Mr Peter McGrath, General Manager, would appear to come from an unspecified person within the NEhB area. From the provided minutes of a meeting between Dr Neary and Mr Finbar Fitzpatrick (INCA), the reports would appear to be from non-medical personnel.

3. The allegations made against Dr Neary specifically refer to his rate of Caesarean Hysterectomy and Episiotomy rate. -No information regarding his Episiotomy rate is provided and therefore we can make no comment with regard to this. We have therefore confined our investigation to those cases who had a Caesarean Hysterectomy or Peri-Partum Hysterectomy because of post-partum haemorrhage have reviewed photocopies of the charts of all patients in the above two categories in the years 1996 - 98 (to 1st November). These photocopies were provided by Dr Neary .

Introduction

Reason for report : Dr Michael Neary, a consultant Obstetrician and Gynaecologist in Drogheda has received a letter from the North Eastern Health Board detailing certain perceptions concerning his practice, with particular reference to the number of Caesarean hysterectomies carried out under his care at Our Lady of Lourdes Hospital in Drogheda. He has been informed of the wishes of the health board to hold an enquiry into his practice and -of their wish that he suspend practice during any such investigation.
-
This report is a preliminary report following brief-examination of the case records of those patients who have had caesarean hysterectomies under the care of Dr Michael Neary' during the last three years, and a study of the caesarean hysterectomy rates in the hospital during the. three years ,1996 to 1998. Because of the immediacy of the situation we have had insufficient time to prepare a comprehensive report but-have sought to determine whether or not there are grounds for:

a) an investigation into Dr Neary's Practice
b) whether it is in the patients or the health. board's interests to suspend Dr Neary during any such investigation.- -

Background

Our Lady of Lourdes Hospital in Drogheda provides a large clinical- Obstetric andGynaecology service to the women of the catchment area and delivers about 2000 babies per annum. Dr Michael Neary has been a consultant Obstetrician and -Gynaecologist at the hospital since 1974. .
Report findings

We have examined .the maternal mortality rate at the hospital during this time-and in the immediately preceding years i.e. from 1960 until 1997), details of the caesarean hysterectomy rates during these years and details of the number of post partum hysterectomies carried out by the different clinicians at the hospital bet ween 1996 and 1998. We have further examined details of the number of deliveries by consultant, gynaecological outpatient activity at the hospital according to Consultant and waiting lists.

We have noted the following factors which we feel are relevant to the present investigation

1. The hospital has an ethical code which impacts significantly on Obstetrics, Gynaecology and preventive health care for women of the area. Doctors working at the hospital are not allowed to provide many of the preventive health care services that they and their patients deem appropriate. In particular women do not have access to a wide range of contraceptive choices including all of the so called artificial methods of contraception (particularly sterilisation, even in situations where medical opinion is that further pregnancy would be life threatening to the woman). This has placed the Obstetricians in an extremely difficult position. - Women in the area not uncommonly request a permanent method of contraception at the time of caesarean section and this has led to some cases of caesarean - hysterectomy being performed at the hospital, which would not otherwise have been performed. In hospitals where such limitations on female sterilisation, does not prevail a simple and much safer procedure would be undertaken.
2 Dr. Neary informed us that he sees most of the public patients who have had a previous caesarean section in his antenatal clinic.

3 Injectable Prostaglandin preparations (Hem bate, PGF2. alpha) which would be-used in the Coombe Women's Hospital in cases of severe post-partum haemorrhage, are not available in the Lourdes Hospital for the management of acute severe primary post partum haemorrhage

4 The rate of caesarean hysterectomy is high in the unit as a whole and as a result the clinical experience gained by its' most senior consultant is considerable. In view of the fact that these operations have (as far as we are aware) not been especially morbid it may be that there is an ethos in the unit for performing these procedures at a lower threshold than elsewhere. Because Dr Neary-is the most experienced Obstetric surgeon in the department it is not surprising that he has been called to attend many of the severe post partum haemorrhages which occur. Furthermore when a decision to perform a caesarean hysterectomy has been made (by another colleague) it is not surprising that Dr Neary is often called to give assistance.

5 Surgical procedures employed elsewhere (for example internal iliac artery ligation) are procedures that are not (as far as we are aware) within the rernit of the general surgeons common clinical practice (and therefor-experience)- such that there is not a readily available specialist vascular surgical consultative service in emergency situations. This limits the therapeutic'. options available to the Obstetricians

The individual cases

We have divided these into three groups. Firstly those patients in whom a decision to perform hysterectomy was made at the time of Caesarean section. Secondly those patients who had a puerperal hysterectomy following a vaginal delivery (not strictly caesarean hysterectomy); and finally those patients who-requested a caesarean hysterectomy. We have inspected photocopies of the case notes of these patients and obtained the following information

Group 1 Patients who had a Hysterectomy as an emergency procedure at the time of Caesarean Section.

Case 1 (Chart no 31351) 3rd child. Date of operation 14 Jan 1998 Known case o p acenta previa, Grade III. Inpatient for 10 weeks. Elective Caesarean Section 14 -Tan 1998, massive intra-operative bleeding from lower segment, supracervical hysterectomy,, uneventful recovery. Dr Neary stated that he considered the hysterectomy a life saving procedure.

Case 2 (Chart no 25185), 2nd child. Date of operation 31 Jan 1996 Emergency call in to a Caesarean Section already in progress for failed instrumental delivery. Found uterus had ruptured and lower segment `in shreds' Baby boy of 9lbs:8ozs delivered, emergency supracervical hysterectomy for uncontrolled bleeding. Uneventful recovery.

Case 3 (Chart 28055) 2nd child. Date of operation October 1998 -
Known Grade placenta Previa, continuous vaginal bleeding. Elective Caesarean Section at 33 weeks gestation. Massive intraoperative Bleeding, no surgeon available to tie uterine or internal iliac arteries. Supracervical hysterectomy, Uneventful recovery.

Case 4 (Chart no 28092) 1st child Date of operation 17 August 1996: Previous spontaneous miscarriage at 22 weeks gestation complicated by manual .removal of the placenta. Emergency Caesarean Section after spontaneous onset of labour for secondary arrest at 6c ms dilatation. Intraoperative bleeding of >2000mls in 10 minutes.. Ten pound baby, supracervical hysterectomy. Uneventful recovery. Spinal anaesthesia in use and patient aware of decision to remove uterus.

Case 5 (Chart no 28055) 2nd child. Date of operation 30 Jan 1997. Previous Caesarean Section. Elective repeat Caesarean Section at 38 weeks gestation because of breech presentation and big baby. Healthy baby 81bs 15ozs. Atonic PPH not responsive to appropriate available medical treatment, Weighed blood loss. of 1800mls.
Supracervical hysterectomy. Uneventful recovery.

Case 6 (Chart no 28144) 3rd child. Age 2-9. Date of operation 17 April 1996.
Two previous Caesarean Sections. Repeat elective Caesarean. Section. Atonic uterus with massive PPH not responsive to appropriate available, medical therapy. Supracervical hysterectomy. Uneventful recovery.

Case 7 (Chart no 32483) 1st pregnancy.. Age 20. Date of operation 5'n October 1998.
Previous Left salpingo-oophorectomy. Elective Caesarean Section for breech presentation: Massive-bleeding from the right side of the uterus. Received appropriate medical treatment. Bleeding continued, Operation performed under spinal anaesthetic and patient appraised of the situation throughout. Clinically suspected to have a developmental uterine anomaly on the right side. Supracervical hysterectomy. Uneventful recovery.

Group 2. Patients who had a peri-partum hysterectomy for post-partum haemorrhage

Case 1 (Chart no 29641) Age 30, 1st pregnancy. Date of operation 17 Jan 1996
Spontaneous rupture of the membranes at 22 weeks gestation. Admitted and prescribed antibiotics. Intrauterine Fetal Demise. Spontaneous delivery of a macerated stillborn baby at 26 weeks gestation.. Sudden massive PPH. No response to appropriate medical treatment. Patient near death. Placenta retained. Supracervical hysterectomy for placenta increta, placenta abserved to be almost penetrating to serosal surface of the uterus. Uneventful recovery.

Case 2 (Chart no 25241) Age 28, 1st pregnancy, Date of operation 9 March
1998.
Spontaneous vaginal delivery, 71b doe girl. Massive primary atonic PPH appropriate medical measures taken, Uterus packed, supracervical hysterectomy for continued bleeding.. Uneventful recovery.

Group 3. Patients undergoing elective Caesarean Section and who requested Caesarean Hysterectomy if in the. opinion of Dr Neary, further pregnancy carried a substantial risk to maternal health.

These cases would, we feel, have been treated by tubal ligation rather than hysterectomy if that option was available. We regard these cases as a reflection on the restrictive attitude to female sterilisation prevailing in the Lourdes Hospital which we feel is contrary.to both Department t of Health policy and the Patient's Charter. We were shown correspondence. by Dr Neary to the Health Board, the Hospital Management, the Department. of Health and the Medical Defense Union, extending back over 15 years, appraising them of this situation. We feel that in these instances Dr Neary acted in the best interests of the patients in the difficult circumstances in which he works and do not consider that these cases need investigation or comment in the context of the present enquiry. A total of 8 Caesarean Hysterectomies were carried out on such patients in the triennium 1996 to 1998.

Conclusions

We have scrutinised photocopies of the case notes of 9 patients who underwent emergency hysterectomy in the three years 1996 to 1998 in the practice of Dr Michael Neary in Our Lady of Lourdes Hospital, Drogheda. Seven of these patients had an. emergency Caesarean Hysterectomy for intra-operative haemorrhage and two had a post-partum hysterectomy because of haemorrhage that had not responded to appropriate medical therapy. We note that Dr Neary was called into a further 5 cases during the triennium in question in which the decision to perform a hysterectomy was taken by another medical practitioner and where Dr Neary's expertise in this procedure was requested. We-further:. note that four of the five cases were in 1996, one during 1997 and. that there was no such case during 1998. We also note that during the year 1998 up to the date of this report, from statistics provided by Dr Neary that his rate of Caesarean Hysterectomy is 5.8% (5/86) of Caesareans, Dr Finian Lynch's is 1.7% (1/58) and Dr Seosamh O Coighligh's is 7.5% (2/27). Therefore compared with his consultant colleagues, Dr Neary's rate is not excessive.

Having reviewed the casenotes, we are of the opinion that all o£ the nine cases reviewed can be justified in the prevailing situation. We note that if female sterilisation were available In the Lourdes Hospital that the incidence of Caesarean Hysterectomy would be reduced by 50% immediately. We find no evidence of questionable clinical judgement, poor operative ability or faulty decision making. Quite the contrary, we find that Dr Neary, in the exercise of his clinical judgement, has under difficult circumstances probably saved the lives of several mothers. We note that some of the mothers may have been undertransfused after operation but accept Dr Neary's explanation that these mothers were very reluctant to receive even the volume of blood that was transfused as we have the same experience here in the Coombe Women's Hospital. We do not now transfuse patients for postpartum anemia unless they are symptomatic and with a haemoglobin of less than 7 grams/dl.

On the evidence presented we find no grounds to suspend Dr Neary or to place any restrictions on his practice (public or private).

We recommend that the North Eastern Health Board take urgent steps to implement the following practical procedures. .

1. That female sterilisation be made available where considered by the patient and her attending Obstetrician. This is the practice in the majority of obstetric units in the state and is in accordance with Department of Health policy.

2. That Prostaglandid F2alpha be available to treat refractory cases of postpartum haemorrhage.

3. That appropriate surgical back-up from 'a surgeon trained in vascular surgery be available for consultation in cases of uncontrollable postpartum or intraoperative bleeding. We do not consider it appropriate that Mr Frank Cunningham should be called from Navan for this purpose.

Signed: Walter Prendiville
Walter Rrendiville M.A 0., F.RC.O.G., F.RAC.O.G. Associate Professor, Royal College of Surgeons in Ireland RCSI Dept of Ob/Gyn Coombe Women's Hospital' Dublin 8.

Signed: Bernard Stuart
Bernard T -Stuart M.A.0., F.R.C.O.G. Consultant Obstetrician & Gynaecologist Coombe Women's Hospital and St James's Hospital, Dublin 8
Dated 4th November 1998

Appendix 2

Report

To. Mr. Finbarr Fitzpatrick Secretary General, IHCA
From: Dr. John F. Murphy . .

Purpose of Report

This is an initial report concerning the need for an investigation into the obstetric practice of Dr. Michael Neary Our Lady of Lourdes Hospital Drogheda with reference to the rate of caesarean hysteractomy.

Subsequent to your telephone conversation of 4th November 19991 interviewed Dr, Neary in detail and reviewed photocopies of 17 charts of patients who had undergone the operation of Caesarean hysterectomy in the years 1996 1997 and to date 1998 in which a hysterectomy at the tuna of caesarean Se Section or very shortly
after vaginal delivery was carried out

I. This report has been prepared by Dr. John P. Murphy, MD. FRCPI.,FRCOG, Consultant Obstetrician and Gynaecologist National Maternity Hospital Consultant Gynaecologist, St. Vincent's Hospital Dublin,

2. Further information about the author of the report

I currently represent Irish Obstetricians and Gynaecologist an the Council of the Royal College of Obstetrics and Gynaecologists in London. I am an elected Council member and treasurer of the Royal College of Physicians of Ireland. For tan years I was Editor of the Irish Journal of Medical Science.

Background information ascertained concerning the possible investigation or Dr. Neary.

I. Dr. Neary has been a Consultant Obstetrician Gynaecologist at the Lourdes Hospital since 1974, Prior to his appointment there had

been a relatively high Instance of Caesarean hysterectomy at the Lourdes Hospital since 1961; thirteen years before Dr. Neary's appointment,

2. As far as I can ascertain there has not been my complaint from a patient concerning the need for caesarean hysterectomy nor to the best of my knowledge has any medico legal action been initiated consequent on these cases. The complaint apparently comes from a person m persons unspecified working within the North Eastern Health Board area. It might appear fm notes provided that these are non-medical personnel.

3. Allegations are made against Dr. Neary specifically referring to his rate of Caesarean hysterectomy and his Episiotomy rate. episiotomy rates are of course so subjective that it would be impossible to give a retrospective opinion on this rate.. The rate for any obstetrician or midwife can be zero if tears are allowed to happen. I therefore confine my study to those cases where a hysterectomy a Caesarean Section was carried out or shortly following delivery because of post-partum haemorrhage. Copies of all notes I looked at have been provided by Dr. Neary. This report is a preliminary one following a. brief examination of those notes and a discussion with Dr. Michael Neary. There is a requirement for an immediate report and I have concentrated an the following;

(a) The proposed investigation into Dr. Neary's practice concerning the allegations of caesarean of peri-partum hysterectomy;
(b) Whether it is in the interest of the North Eastern Health Board and the patients who benefit from the obstetric service in that area to suspend Dr. Neary during such an investigation.

Our Lady of Lourdes Hospital, Drogheda .

l. This is an important hospital with a large clinical obstetric gynaecology service to women in that catchments area with a delivery of about 2,000 babies per year. Dr. Neary is now the senior consultant and has been a consultant at the hospital since 1974. The hospital has a well defined code of ethics that forbids tubal ligation and indeed I believe any discussion with patients concerning artificial contraception. This codes of ethics places doctors working in the 1990s in Ireland in an almost impossible situation. Women in all areas in Ireland no uncommonly request tubal ligation at a time of caesarean section and this in Our Lady's Hospital has led to a situation nowhere caesarean hysterectomy is carried out rather than a tubal ligation as would be the practice in any other hospitals. In hospitals with no such strictures on female sterilisation tubal ligation at the time of caesarean section is a significantly simpler and safer procedure. It should also be noted that Dr. Neary's clinic seems t attract more patients who have had a previous caesarean section than other clinics.
2. The rate of caesarean section is relatively high in the unit and this results in and expertise carrying out this operation which may not be present in other units. Because of Dr. Neary's seniority and skill he is from time to time called to assist other practitioners, both consultant and junior who are in difficulty with caesarean sections. In that area of the North Eastern Health Board there is no facility for surgical procedures employed elsewhere (ligation of the internal ileac artery) and there is no vascular surgeon or surgeon dedicated to the practice of gynaecological oncology. This limits the surgical options and predicates in favour of caesarean hysterectomy.

Background features to Obstetrics in the Western World in the 1990s

1. The Caesarean Section Rate

The rate of Caesarean Section in the western world. Has been climbing relentlessly over the past two decades. Rates of 20% or more are not uncommon. These increased rates are driven by:

(a) The unacceptability by parents and indeed society to any intra-partum problem.
(b) The huge medical-legal problems particularly pertaining to obstetrics
(c) The lower parity to mothers
(d) The fear of anal sphincter and pudendal nerve damage during vaginal delivery. This is becoming a very real issue.
(e) The increase rate of primary caesarean section making repair section much more likely
2. Even in centres with a reputation for a low rate where huge efforts is expended to maintain low rates (National Maternity Hospital, Dublin) the overall rate is more than doubled in the past 15 years.
3. Caesarean section is like any other operation. It is associate with complications; the more carried out the more problems.

Fertility Issues

There is no doubt that issues of fertility and family planning have played a significantly greater role in obstetric practice over the past number of years. Elective tubal ligation is now commonplace in most maternity hospitals. Tubal ligation is usually discussed din women having a second or more caesarean sections or in a first caesarean section when there have been previous vaginal deliveries. Repeated pregnancy in women who have had a caesarean section propose a real risk, rupture of the uterus (a life threatening situation for mother and baby), difficulty with future surgery, haemorrhage, compromise to adjacent organs etc. One frequently advises women how had had multiple caesarean sections to carefully consider future pregnancies and tubal ligation is frequently offered at the time of such repeat operations. When tubal ligation is not possible because of the ethical code of a particular institution the operation of subtotal caesarean hysterectomy (with the patient's agreement) is tempting. It could in other circumstances be classified as "an Irish solution to an Irish problem". In decades past it was frequently carried out. In considering this the hospital authorities must be aware of the policy of the department of Health and indeed the |Patients Charter with regard to tubal ligation.

Haemorrhage

Since pre-history haemorrhage, particularly obstetric haemorrhage has been the course of human kind. There is little in medicine that would translate a healthy female into a corpse more quickly than obstetric haemorrhage. The history of Europe and perhaps the world had been altered dramatically consequent by an episode of post-partum haemorrhage in the early part of the 19th century. Severed obstetric haemorrhage is dramatic, like a blazing out of control fire. It has to be contributed immediately by dramatic measures. What one does with copious haemorrhage can only be decided on at the time. retrospection by others as to how an acute haemorrhage might have been managed is futile and unrewarding exercise.

The obstetrics under lay scrutiny

During the past decade or more obstetrics has changed dramatically in comparison with all other acute medical disciplines. This is because all actions of an obstetrician can be observed and scrutinised at an immediate level by non-medical or paramedical personnel. It is particular so at caesarean section in that

(a) The mother is often fully awake under spinal anaesthesia. This form of anaesthesia can make surgery much more difficult.
(b) There is almost invariably a husband/partner present.

No other branch of surgery is there a situation nowhere the patient and her husband are so involved in major surgery. At caesarean section blood loss of a significant amount is not uncommon. This is being observed by non-medial personnel. There is always also the possibility of difficulty with delivery of the baby again observed by non-professionals. This puts huge stress on the operator. If events (and there will always be events) go badly the stress is very great.

Resistance by patient and doctors to the transfusion of blood and blood products.

During the past number of years there has built up a great resistance to blood transfusion. This is for many reasons not least of which is the fear of Hepatitis consequent on the anti D situation. Obstetric practitioner go to very great lengths to avoid blood transfusions or when absolutely necessary to give a minimal transfusion. This may well have influenced Dr. Neary in hereditament present situation with regard to the low volume of blood transfusion and subsequent low haemoglobin's in certain patients.

The individual case under scrutiny

I have divided these into four groups, firstly, patients who had a hysterectomy at the time of caesarean section ad where Dr. Neary was the principal surgeon, secondly, those patients who had a hysterectomy following a vaginal delivery (not really caesarean hysterectomy) thirdly, those patients who requested a caesarean hysterectomy who in other circumstances would have been offered a tubal ligation fourthly, those cases where Dr. Neary was called in to assist colleagues, consultant or junior. It is my opinion that it is only the first two groups that require detailed scrutiny.

Group 1 patients who had a caesarean hysterectomy with Dr. Neary as the principal operator.

Case 1 Chart No. 28144 3rd Child – repeats elective caesarean section under spinal operation. Dramatic haemorrhage from the fun of hereditament uterus, Oxytocin and ergotmetrine used. Adonic uterus with no response to usual medical therapy. Subtotal hysterectomy – loss estimated at 1300mls. Post-mortem haemoglobin 10. uneventful recovery. This was in my opinion appropriate management.

Case 2 Chart No. 25185 2nd child. Date of operation 31st January 1996. This was an emergency call in by a registrar with his membership following a failed attempt at vacuum delivery. The uterus had ruptured with copious bleeding from one of the angles. Hysterectomy was carried out. Baby weighed 9lbs 8ozs. Estimated blood loss 1500mls. This in my opinion was a life saving procedure, as rupture of the uterus is a well-known cause of maternal death.

Case 3 Chart No. 28092. This patient had previously spontaneous miscarriage at 23 weeks gestation. Labour started spontaneously. There was secondary arrest at 6cms following 10 hours of labour. a caesarean section was carried out. There was massive intraoperative bleeding with an estimated loss of 2.5lts. Appropriate medical therapy was tried without success. Spinal anaesthesia was in place and the patient was aware of the emergency and the decision to remove her uterus. The baby weighted 10lbs. This in my opinion was a life saving procedure.

Case 4 Chart No. 28055. Date of operation 30th January 1997. This patient had previous caesarean section and was having a repeats elective Caesarean section at 38 weeks gestation because of a large baby presenting by the breech. The baby was healthy and weighed 8lbs 15ozs. She had a substantial bleed during the Caesarean section with several bleeding points throughout the uterine cavity. She had a hysterectomy and the haemoglobin dropped form 13 to 9 grms%. There is a suggestion that this patient may have been very reluctant to receive blood.

Case 5 Chart No 32483. This patient was aged 20 and had previous surgery on her uterus, her left tube and ovary having been removed elsewhere, she was first seen at 33 weeks with significant anaemia. She had a breech presentation and the malpresentation remained. She had an elective Caesarean section at 39 weeks and anterior placenta previa was found. There was copious bleeding from the right angle of her uterus. The patient was under a spinal anaesthetic. Oxytocin ergometince hot packs etc. were used to no avail. A hysterectomy was carried out. It is likely that he patient's previous surgery and the degree of placenta previa contributed significantly to this problem.

Case 6 Chart No. 31351. Aged 26 – two previous deliveries. Antepartum haemorrhage at 27 weeks. A scan showed a major degree of placenta previa. In-patient for the remainder of pregnancy. Elective Caesarean section at 38 weeks. Substantial bleeding below the whole Caesarean section scar. A clinical diagnosis of placenta increta. There was bleeding from the right uterine artery area and a haematoma developed in the right broad ligament. A subtotal hysterectomy was carried out. Dr. Neary describes this as one of the most difficult operations he has ever undertaken. The association of a previous Caesarean section a placenta increta and a broad ligament haematoma is a potentially lethal combination.

Case 7 Chart 28055. Aged 31. previous Caesarean section for foetal distress. Known placenta previa, no bleeding so no admitted. Admitted as an emergency at 31 weeks with a substantial antepartum haemorrhage. Every time she moved she bled. She was maintained in hospital for 13 days. Steroids were administered to mature the baby's lungs. At 33 weeks she had an elective Caesarean section because of the bleeding. She had a grade IV placenta previa which was incrota. There was substantial intra-partum bleeding with multiple sutures placed. She was still bleeding following the hysterectomy and had to have her cervix removed by combined vaginal and abdominal approach. Dr. Neary considered this a life saving procedure and I agree with him.

Group 2 patents who had a peri-partum hysterectomy following vaginal delivery.

Case 1 Chart No. 25241. This patient had a spontaneous vaginal delivery and manual removal of the placenta, which was thought to be acreta on the right side. Massive post-partum haemorrhage, packing Oxytocin etc. Decision to carry out subtotal hysterectomy. Histology showed a placenta acreta. This was a life saving procedure.

Case 2 Chart No. 29641. this was a patient expecting her first baby who was admitted with spontaneous rupture of the membranes at 22 weeks. She developed pyrexia and presumably chorio anmionitis. The baby died. She had a drip induction delivering a macerated infant. There was massive haemorrhage following the delivery with the placenta still in place. The patient almost exhengranated and had an emergency hysterectomy. This was considered life saving by Dr. Neary and I agree.

Group 3 patients undergoing elective Caesarean section who required hysterectomy if in the opinion of Dr. Neary a further pregnancy carried a substantial risk to the mother's life and/or health.

If the option of tubal ligation existed this would be the preferred choice of surgery. I regard these cases as a reflection of the attitude to female sterilisation prevailing in the Lourdes Hospital, a situation which has significantly changed in other hospitals; voluntary and health board. The policy in the Lourdes Hospital seems to contravene the wishes of the department of Health and indeed the patients charter.

Dr. Neary has over the years been in correspondence with the hospital authorities, the health board, the department of Health and his own defence union concerning this situation. It is my opinion that in ach instance Dr. Neary acted in the best interest of his patient in a difficult circumstance. I do not think in the limited time available to me at the moment that these cases need to be discussed in detail. A total of eight Caesarean hysterectomies were carried out on such patients in the years under review,

Group 4 cases where Dr. Neary was called in to assist in surgery initiated by another doctor.

I do not think these cases require scrutiny in the limited time available to me as Dr. Neary was essentially helping a colleague. The only question that Dr. Neary might have to answer the appropriateness of delegation when the other doctor was a junior. From my perusal of the notes it would seem that the delegation was appropriate.

Conclusion

I have scrutinised the photocopies of the notes presented to me of the nine patients who underwent emergency hysterectomy in the three years 1996 to 1998 at the practice of Dr. Michael Neary in Drogheda. Seven of these patients had intraoperative haemorrhage and tow had a post-partum hysterectomy because of haemorrhage, which had not responded to appropriate therapy. Dr. Neary was called in to a further five cases during the three years in question to help a colleague. Dr. Neary's undoubted reputation at management of post-partum haemorrhage was in my opinion life saving in these cases. From data provided by Dr. Neary his rate of Caesarean hysterectomies is not dramatically different from that of his colleagues.

It is my conclusion that Dr. Neary has no case to answer concerning his management of any of the patient in question. On the contrary it would seem to me that the North Eastern Health Board has a number of situations which need to be dealt with urgently.

1. A more enlightened attitude by management is required into the intrinsic risks of motherhood and the stresses of contemporary obstetric practice on all involved at a clinical level.

2. Female sterilisation should be made available and this would significantly reduce the number of Caesarean hysterectomy.

3. There should be appropriate surgical backup and the provision of vascular surgery should be examined.

4. The methods of dealing with perceived high rates of intervention should be dramatically altered. There must be some way where the practice of a senior and highly respected obstetrical can be evaluate on a mutually agreed basis without fear of suspension, legal action and so on.

It is my firm conclusion that Dr. Neary should continue to work in Our Lady Of Lourdes Hospital pending any forma investigation. It would be wrong to put restrictions on his practice and it is my view that the mothers of the North Eastern Health Board hare fortunate in having the service of such an experienced and caring obstetrician.

John F. Murphy
Dr. J.F. Murphy, MD., FRCOG, FRCPI

5th November 1998

Appendix 3

REVIEW OF SELECTED CASES OF OBSTETRIC HYSTERECTOMY
PERFORMED BY DR MICHAEL NEARY
AT OUR LADY OF LOURDES HOSPITAL, DROGHEDA-.

Dr M Maresh MD FRCOG

Consultant, Obstetrician & Gynaecologist, St Marys Hospital, Manchester, England. Honorary Senior. Lecturer, The University of Manchester

The following report has -been produced at the request of Dr Ambrose McLoughlin, North Eastern Health Board, Ireland.

The report has been based on. review of 9 case notes and statistics for caesarean -hysterectomy- at Our Lady of Lourdes. Hospital,

Drogheda and Dublin maternity hospitals.

December 3rd 1998

1. Background

An obstetric hysterectomy is performed because of uncontrollable haemorrhage from the uterus following birth, usually associated with a caesarean section. It is performed when the various measures which have been taken to control the bleeding have failed and there is concern over the woman's life. Such a decision is taken by a consultant. In view of the rarity of the problem and the difficult .manoeuvres required to try to stop the bleeding another consultant may sometimes be called in to assist, as the registrar helping the consultant is unlikely to have ever had experience of the procedure. Hysterectomy prevents the. woman ever having any more children and therefore in young women, who have not completed their family, great efforts must be taken to avoid: this. However delaying performing a hysterectomy with continued bleeding will cause its own problems. Excessive bleeding is associated with reduced clotting of the remaining blood and therefore haemorrhage may increase. (Giving a blood transfusion on its own will not correct this). Accordingly the decision to abandon conservative measures to save the uterus and proceed to hysterectomy is difficult, another reason why today a second opinion should be considered:

2. Audit data

Review of audit data for the hospital shows that there has been a sudden increase in the rate of hysterectomy performed at caesarean section from an average of 1 a year (1994-95) to about 9 a year (1996-8). 21 of the 27 hysterectomies were performed by one consultant. Hysterectomy at the time of caesarean section has to be performed occasionally and one might expect one case in a year at a hospital this size. In view -of the random nature of problems the rate might vary between 0-3, but more often than not between 0-1. Annual review of the data for 1996 should have caused some concern. Adverse event monitoring is advised in obstetrics and caesarean hysterectomy is regarded as an adverse event. Accordingly one would have anticipated that sometime during 1997 an inhouse analysis would have been performed by the medical staff to assess whether anything should be done _ to reduce the number of caesarean hysterectomies: It seems improbable that this occurred as the high rate has continued.

3. Individual cases

The case notes of nine women who were patients of Dr Neary's and who had obstetric hysterectomies performed over the period January 1996 - October 1998 have been provided for review. Each case is summarised on a specific proforma and these are attached to this report. It is clear that the. cases were-complicated, but one would expect. a consultant to. be able to safety manage them. While recourse to hysterectomy might have occurred in a 'few of the cases if another consultant had been in charge, that so many hysterectomies were required over so short a time period is worrying. All nine cases reviewed exhibit a number of features which cause concern and these Features recur. These are now discussed.

3.1 Incorrect recording of findings

Dr Neary has reported a number of findings in the notes which are not confirmed on the pathological examination of the uterus. These apparently incorrect recordings are features which could be associated with excessive bleeding.
3.1.1 Five cases of placenta increta.( ) None were reported as increta (placenta invading myometrium) although one case ( ) was reported, as accreta (placental tissue morbidly adherent).

3.1.2 Two cases of placenta praevia ( )

3.1.3 Three cases of a defect or weakness in the fundus of the uterus ( )

3.1.4 One case whole left side of uterus ruptured ( ).

3.2 Rapid recourse to caesarean section

3.2.1 In four cases blood transfusion was not felt necessary at the time despite the haemorrhage being "uncontrollable" ( ) "a`lot" ( ), "copious non-stop" (( ) and continuous ( ). One of the four ( ) was subsequently found to be anaemic and was transfused. In addition two cases were only transfused post operatively when the bleeding had been described as "massive" ( ).

3.2.2 In four cases the anaesthetist's observations of pulse and blood pressure were stable during the time of the haemorrhage ( ).

3.2.3 In the two cases where-there was independent timing of events ( ) the decision to proceed to caesarean section appears to have been rapid.

3.2.4 Measures to control haemorrhage (other, than the use of oxytocin) are variably recorded with minimal being recorded in some cases ( )

3.2.5 Most of the hysterectomies were undertaken during normal weekday working hours when facilities and backup support should have been optimal. Indeed 5 of the 7 hysterectomies associated with .caesarean sections occurred when the caesarean was being undertaken electively.

3.2.6 Three women ( ) were- having their first baby and one would have expected major efforts to be undertaken to preserve their fertility, particularly so in ( ) case where she had lost her baby. .

3.3 Other areas of clinical management concern

3.3.1 Performing an elective caesarean at 33 weeks when the mother was not bleeding significantly at the time ( ) put her baby at unnecessary neonatal. risk.

3.3.2 Management of-intrauterine-sepsis with a dead fetus ( ). She was left with a dead fetus and with ruptured membranes for about 60 hours after the diagnosis of septicaemia was made. Dr Neary stated "fortunate not to have a maternal death". I would agree, but not for the same reasons as Dr Neary implies. ( ) was put at unnecessary risk of. dying from septicaemia which was avoidable. Furthermore leaving her so long with a dead baby in utero was inhumane.

3.3.3 One ovary was removed in four cases ( ). When performing an obstetric hysterectomy it is sometimes easier to remove the ovaries than to retain them. It is unacceptable to remove both as this would make the woman immediately become menopausal. However removing just one means that the woman is then totally dependent on her one remaining ovary. It is normal practice to strive to retain both ovaries and it is concerning that he decided to remove an ovary in four of the. nine cases.

3.4 Exaggeration of events

In a number of cases Dr Neary appears to have exaggerated what actually occurred. The most obvious examples are as follows.

3.4.1 "Most difficult case I have ever seen" ( )

3.4.2 "1 spent most of the night in theatre" ( )

3.4.3 "I felt it was fortunate that the patient survived" ( ).

4 Conclusions

From the information supplied, I have major concerns about Dr Neary continuing to practice currently as a consultant obstetrician. His clinical judgement appears to be, significantly impaired and women appear to be being put at risk. Although my concerns relate mainly to his excessive use of hysterectomy post delivery I do have concerns about other aspects of his management of patients. In addition to his clinical judgement I have concerns about his skills at Caesarean section currently if there are complications. Finally Dr Neary's perception of events appears impaired.

Tragically: many of these women who have been deprived of having children in future were young. Three were having their first-baby. One of the three lost her baby (through no fault of Dr Neary) and so now will never have children of her own.

M. Maresh
M. Maresh

OBSTETRIC HYSTERECTOMY REPORT

1. Name
2 Age -at delivery 28
3 Parity 1 - Caesarean in labour
4 Pregnancy -
5 Labour -
6. Date/time delivery . 17-04-1996 at 1210 -
7 Mode of delivery Elective caesarean
8 Surgical comments "3x2 inch fundal defect. Bleeding ++++
1200 fresh uterine bleeding. Copious
non-stop bleeding [16]
9 Haemostatic measures Ergometrine x2; 40 units oxytocin [I6]

10 Anaesthetic obs Pulse 70 constant from time delivery.
Observations finish 1305 [9]
Spinal . throughput
11 Blood loss 1200 or 1300 [16]

l2 Pre-op Hb 10.5 on 12-04-1996 [27]
13 Post-op Hb 8.1 on 18-04-1996 [7]
14 Transfusion 2 units electively on 18-04-1996
15 Moved to recovery 1310 hrs on 17-04-3.1996
I6 Histology No- report of fundal defect - normal [23] .
17 Correspondence -

COMMENTS. No obvious uterine abnormality (8, 16)

No major degree of haemorrhage indicated by no specific surgical measures needed (8) no blooed transfusion felt necessary (14) stable-observations(10)

nb [ ] relates to pages in patients notes

OBSTETRIC HYSTERECTOMY REPORT

1 Name
2 Age at delivery - 37
3 Parity 3 - normal deliveries
4 Pregnancy Normal
5 Labour Normal
6 Date/time of delivery 8-3-1998 at 2314
7 Mode of delivery Normal. Retained placenta- 2335
No bleeding [9]
8 Surgical comments Placenta removed not complete at
0012 [9] - "Placenta accreta right
fundus uncontrollable PH" [18] "packed".

To theatre at 0028 [9]

Hysterectomy. Right ovary stuck on
uterus "RSO" Placenta increta 4X3"
9. Haemostatic measures Syntocinon 00.12,- oxytocin infusion
0013 [5,9].
10- Anaesthetic obs No changes in pulse or BP [5, 10] -
11 Blood Loss 1000ml [8,18].
12 Preop Hb 24-2-98 11.6, periop 9-3-98 13 -613 . Postop Hb 10-3-98 10.8 (24]
14 Transfusion None
15. Tramsfer to recovery 01.48
16- Histology Macros some placenta adherent over
area 7x4":
Micro placental tissue adherent
- to myometrium (accrete) although
no chorionic villi invading myometrium (increta)[30]

COMMENTs. . While placenta was adherent. (though not invading) In absence, of major blood loss hysterectomy was rapidly resorted to without

Apparently considering other courses. Also ovary removed .

nb[ ] relates to pages in patients notes
m.m. 11/98

OBSTETRIC, HYSTERECTOMY REPORT

1. Name
2 Age at delivery 26
3. Parity 1 - normal
4 Pregnancy -
5 Labour induced. Full dilatation 2245.
Failed ventouse 2315.
6. Date/time of delivery 31-1-96 at 2348.
7 Mode of delivery Emergency caesarean.
8 Surgical comments Registrar: "Uterus found ruptured at left side as far as vagina [16]

Dr Neary: 'Uterine rupture all left side,'. Uncontrollable bleeding (L) side uterus
...subtotal hysterectomy &: LSO" (left ovary removed as well) .

9 Haemostatic measure's
10 Anaesthetic obs Tachycardia throughout, but pyrexia
Slight BP drop 120/70 to 100/50-60
11 Blood loss 1500m1. measured 1000ml.
12 Preop Hb 11.2 [27]
13 Postop Rb 11.5. [30]
14 Transfusion 4 units -1 theatre [6] 3 after
15 Transfer-to recovery 0125 [83]
16 Histology No specific abnormality [25]
17 Correspondence "Whole left side of uterus ruptured. Absolutely uncontrollable and

massive bleeding. I spent most of the night in theatre … "

Comments Discrepancy between operative, findings and pathology report.

Haemostatic measures unclear. Ovary removed as well.

nb [ ] relates to pages in patients notes
m.m. 11/98

OBSTETRIC HYSTERECTOMY REPORT

1 Name
2 Age at delivery 33
3 Parity 1 caesarean section
4 Pregnancy -
5 Labour -
6 Date/time of -delivery 30-0l-1997 at -1620 hours
7 Mode of delivery Elective caesarean
8 Surgical comments "weakness fundus 3" x 2" - no muscle. PPH continuous" -[36]
9 Haemostatic measures None surgical record-ed [36]. Ergometrine xl, syntocinon infusion
10 Anaesthetic obs Spinal throughout

Pulse, BP stable [30].

11 Blood loss 1500ml; weighed loss -1790 [36]
12 Preop Hb 13.2 on 28-01-1997 [46] .
13 Postop Hb 9.8 on 31-01-1997 [44].
14 Transfusion None
15 Transfer to recovery 1740 hours
16 Histo1ogy No abnormality noted [41)
17 Correspondence -

COMMENTS No obvious uterine abnormality (8, 16). No major degree of

Haemorrhage indicates as no specific surgical methods needed
(9) no transfusion felt necessary (14) stable observations (10)

nb [ ] relates to pages -in patients notes
m.m: 11/98

OBSTETRIC HYSTERECTOMY REPORT

1 Name
2. Age at delivery 32
3. Parity 0+1 - 23 week miscarriage
Pregnancy -
5. Labour Failure to progress at 6cm
6 Date/time of delivery 17-8-96 at 1155 hours
7 Mode of delivery Emergency caesarean [41]
8 Surgical comments . "fundal area 3"x2½ " no muscle massive heavy fundal bleeding

1500-2000ml in 10 mins [41]

9 Haemostatic measures Fundal massage, hot packs [41] Oxytocin, syntometrine, oxytocin

infusion [33].

10 Anaesthetic obs. Epidural [32] . Pulse increase from 80 to 110 between 1200

to 124H BP no change [33].

11 Blood loss 2500ml measured [41]
12. Preop Hb 10.8 on 17-8-96 (Preop) [51]
13. Postop Hb 9.7 on 19-8-96 [48]
14 Tansfusin 2 units - 1 theatre, 1 reccovery [33]
15 Transfer to recovery 1310 hours [71]
16 Histology . No abnormality- [47]
17. Correspondence

COMMENTS No confirmation of weak area uterus measured (18, 16)

blood loss high when consider hb (1 – 13). Attempts-were made
to stop bleeding for a short time.

n.b [ ] relates to pages in patients notes
m.m 11/98

OBSTETRIC HYSTERECTOMY REPORT

1 Name
2 Age. at delivery 26
3. Parity 2 Normal deliveries
4 Pregnancy Bleeding from placenta praevia at 27 weeks..

Remained in patient.

5 Labour None

6 Date/time of delivery 14-1-98 at 1031
7 Mode of delivery Elective –caesarean
8 Surgical comments Posterior placenta praevia increta A lot of bleeding

below incision. Haemostasis not possible. One of most
difficult problems. I have dealt with. Right ovary removed as haematoma [16,17]

9 Haemostatic measures Oxytocin 10 units
10 Anaesthetic obs Pulse 95 to 110, BP120/70 t0 100/60
11 Blood loss 16OOm1 [16]
12 Preop Hb 13.2 12-1-98 [122]
13 Post op Hb 10.3 20-1-98 [119]
14 Transfusion No [91]
15 Transfer to recovery 1150
16 Histology Normal
17 Correspondence "I felt it was fortunate that the patient survived" [67]
Comments While hysterectomy may be needed with placenta pravia this was an elective caesarean with blood available. It did not appear that difficult (despite comments) and haemostatic measures are unclear. Also she lost an ovary.
nb .[ ] relates to pages in patients notes
m.m. 11/98

OBSTETRIC HYSTERECTOMY REPORT

1 Name
2 Age at delivery 20
3 Parity 0
4 Pregnancy Breech presentation. Ultrasound

placenta anterior upper [31-3]

5 Labour None
6. Date/time of delivery 5-10-1998 at 1247 hours
7 Mode of -delivery Elective caesarean [9]8 Surgical comments "Ant. Pl.Praevia. Pl.increta. Uterus spongy all R side .

Very thin R side of uterus. Massive non-stop arterial bleeding.. [9]

1305 decision for hysterectomy [19]
9 Haemostatic measures R uterine artery clamped [9] Oxytocin x1 iv, syntometrine x1 im,
Oxytocin infusion [53]
10. Anaesthetic obs Slight increase pulse rate 100 to 110, BP no obvious drop [53]
11 Blood loss 1400ml [10, 9] .
12 Preop hb 10.8 on 29-9-1998 [64]
13 Postop hb 10.3 on 6-10-1998 [68]
14 Transfusion 2 units between 1415 to 2150 [38]
15 Transfer to recovery 1345 [19]
16 Histology Placenta normal, Uterus no
placenta adherence to underlying myometrium.
17 Correspondence

Comments 20 year old having her first baby. Inconsistency with the placental site and adherence. Decision to perform hysterectomy taken rapidly when loss not excessive and patient stable.

nb [ ] relates to pages in patients notes
m.m- 11/98

OBSTETRIC HYSTERECTOMY REPORT

l. Name
2. Age at delivery 29
3. Parity 0
4 Pregnancy Ruptured membranes 24 Weeks. Admitted, antibiotics scans [52,53] swabs, daily consultant checks. 14-01-96 fetal heart not heard [69] 0030, 15-01-96 pyrexia 39.3 [69] .

Gentamycin started. "drip Wed" [16]
Fetal death confirmed 1200 [51] 16-1-96 augmentin added [16] .

5 Labour Oxytocin started 1130 17-1-96 [70]
6 Date/time of delivery 17-1-96 at 1615 hours
7 Mode of delivery Spontaneous normal of dead baby
8 Surgical comments "Immediately after delivery sudden massive bleeding only partly
controlled by strong bimanual compression. Within 5-6 min almost
exsanguinated. Placenta still in uterus firmly" [22] . At operation
"Placenta praevia incretta almost through uterus completely" [23] .
9 Haemostatic measures Oxytocin x2 & oxytocin infusion
10 Anaesthetic obs General anaesthetic "uneventful" Some BP drop, -

minimal -pulse rise

11 Blood loss 2000ml estimated [22, 23]
12 Pre op Hb 10.9 15-1-96 [33]
13 Post to Hb 12.3.18-1-96 [42]
14 Transfusion 4 units 17-1-96 finish 2200 [111]
15. Transfer to recovery 174-5. on 17-1-3.6
16 Histology "Acute chorioamnionitis. No convincing evidence placenta

accreta seen" [7] .

17 Correspondence "Severe intrauterine infection and septicaemia... treated very

advanced antibiotics.. examination showed placenta praevia increta almost going through uterus completely… fortunate not a maternal death[57]

Comments Delaying in inducing despite death & septicaemia (4) No use of

advanced antibiotics pre delivery (4, 17) No apparent attempt to remove placenta when under GA. No confirmation of placenta praevia, increta or accreta...(4, 8, 16, 17).

nb [ ] relates to pages in patients -notes
m.m. 11/98

Appendix 4

THE MEDICAL COUNCIL

LYNN HOUSE, PORTOBELLO COURT, LOWER RATHMINES ROAD,
DUBLIN, 6.

MEDICAL PRACTITIONERS ACT, 1978

NOTICE OF INTENTION TO HOLD AN INQUIRY UNDER
PART V OF THE ACT

TO: Professor Walter James George Prendiville

(Registration No. 15309)
64 South Circular Road Dublin 8

WHEREAS the Fitness to Practise Committee has received an application from the Medical Council for an Inquiry into the conduct of you, being a registered medical practitioner, on the grounds of your alleged professional misconduct.

NOW TAKE NOTICE that the Fitness to Practise Committee will proceed to hold an Inquiry at 9.30 a.m. on Wednesday and Thursday the 29th November and W' November 2006 and Friday 1st December 2006 at Lynn House, Portobello Court, Lower Rathmines Road, Dublin, 6.

AND TAKE FURTHER NOTICE that the following are the allegations of professional misconduct:

that you, being a registered medical practitioner, failed to show and apply the standards of conduct expected by medical practitioners whilst compiling a report dated the 4th November 1998, in respect of Dr Michael Neary's treatment and management of patients at Our Lady of Lourdes Hospital, Drogheda in that you:

(1) Prepared the said report under circumstances where you did not have adequate time or information, or alternatively did not take adequate time or procure adequate information, properly to prepare the same and/or

(2) Failed adequately to record in the said report the limitations under which the examination leading to the same was conducted and the report produced and/or

(3) Failed adequately to record in the said report important reservations and conditions to which your conclusions were subject and/or

(4) Produced a report that gave an unjustified impression of being independent and/or

(5) Failed to compare in the said report, or record any comparison of, Dr. Neary's rates of caesarean hysterectomy with your own rates or with those at other hospitals and/or

(6) Failed independently to verify, whether by reference to clinical notes or otherwise, that the patients stated by Dr. Neary to have elected to have caesarean hysterectomy did in fact so elect and/or

(7) Stated that all of the nine cases reviewed in the said report could be justified in the prevailing situation when you

ought to have known that some or all of those cases could not be so justified, and/or

(8) Stated that all of the nine cases reviewed in the said report could be justified in the prevailing situation when this was not a conclusion that could legitimately be expressed without also expressing serious reservations in respect of some or all of those cases and/or

(9) Stated in the said report that there was no evidence of questionable clinical judgment or faulty decision making on the part of Dr. Neary in circumstances where there was such evidence in the material available to you and/or

(10) Stated in the said report that there were no grounds to suspend Dr. Neary or to place any restrictions on his practice in circumstances where you ought to have known that there were such grounds, and/or

(11) Stated in the said report that there were no grounds to suspend Dr. Neary or to place any restrictions on his practice in circumstances where that conclusion could not legitimately be expressed without also expressing serious reservations in that regard and/or

(12) Prepared the said report in circumstances where you ought to have known that if its contents were accepted, then the safety of future patients of Dr. Neary would be put at risk.

(13) Such further allegations as may be notified to you.

AND TAKE NOTICE that the nature of the evidence proposed to be considered at the Inquiry and the names of the witnesses whom it is the intention of the Registrar to request to be in attendance at the Inquiry for the purpose of giving evidence are to be found in the Schedule attached to and accompanying this Notice.

AND FURTHER TAKE NOTE that you or any person representing you shall be given the opportunity of being present at such hearing, of being heard and of calling evidence.

AND FURTHER TAKE NOTE that the evidence of alleged professional misconduct shall be presented to the Fitness to Practise Committee in accordance with Section 45 (3) of the Medical Practitioners Act, 1978.

AND FURTHER NOTE that any communication to the Fitness to Practise Committee in reference to this Notice should be addressed to the Registrar and should be either delivered to or left for the Registrar at the office of the Medical Council, Lynn House, Portobello Court, Lower Rathmines Road, Dublin 6, or sent by registered post to such address.

DATED this 22nd day of September 2006

SIGNED John P.Lamont
JOHN P. LAMONT
REGISTRAR

NATURE OF EVIDENCE

Names of witnesses whom it is the intention of the Registrar to request to be in attendance at the Inquiry for the purpose of giving evidence together with a summary of the nature of such witnesses' evidence:

1) A representative of the Medical Council concerning the Report dated 4th November 1998 signed by you and the charts of the nine patients referred to in your said Report, copies of which Report and charts are sent herewith.

2) A representative of the Medical Council in respect of letters to you from the Medical Council dated 31st March 2006 and 2nd May 2006 respectively and your two letters in reply, both dated 2nd June 2006, copies of which letters are sent herewith.

3) Dr Peter McKenna in respect of the matters set out in his Report dated 30th August 2006 and the attachments referred to therein, copies of which Report and attachments are sent herewith.

4) Dr Michael Maresh in relation to the matters set out in his Report dated 3rd December 1998, a copy of which Report is sent herewith.

5) Mr Finbar Fitzpatrick in relation to his meetings and discussions with you on or around 4th November 1998 in connection with the preparation of the said Report dated 4th November 1998, the nature of whose evidence will be furnished to you prior to the commencement of the Inquiry.

6) Dr Michael Neary in relation to his meetings and discussions with you on or around 4th November 1998 in connection with the preparation of the said Report dated 4th November 1998, the nature of whose evidence will be furnished to you prior to the commencement of the Inquiry.

7) Such other witnesses evidence as may be notified to you.

DATED THE 22nd day of September, 2006

NOTICE OF INQUIRY

The Medical Council
Lynn House
Portobello Court
Lower Rathmines Road
DUBLIN 6

Appendix 5

THE MEDICAL COUNCIL

LYNN HOUSE, PORTOBELLO COURT, LOWER RATHMINES ROAD,
DUBLIN, 6.

MEDICAL PRACTITIONERS ACT, 1978

NOTICE OF INTENTION TO HOLD AN INQUIRY UNDER
PART V O F THE ACT

TO: Dr John Francis Murphy

(Registration No. 07253)
Consultant Obstetrician & Gynaecologist
National Maternity Hospital
Holles Street
Dublin 2

WHEREAS the Fitness to Practise Committee has received an application from the Medical Council for an Inquiry into the conduct of you, being a registered medical practitioner, on the grounds of your alleged professional misconduct.

NOW TAKE NOTICE that the Fitness to Practise Committee will proceed to hold an Inquiry at 9.30 a.m. on Wednesday and Thursday the 29th November and 30th November 2006 and Friday 1st December 2006 at Lynn House, Portobello Court, Lower Rathmines Road, Dublin, 6.

AND TAKE FURTHER NOTICE that the following are the allegations of professional misconduct:

that you, being a registered medical practitioner, failed to show and apply the standards of conduct expected by medical practitioners whilst compiling a report dated the 5th November 1998, in respect of Dr Michael Neary's treatment and management of patients at Our Lady of Lourdes Hospital, Drogheda in that you:

(1) Prepared the said report under circumstances where you did not have

adequate time or information, or alternatively did not take adequate time or procure adequate information, properly to prepare the same and/or

(2) Failed adequately to record in the said report the limitations under which
the examination leading to the same was conducted and the report produced and/or

(3) Failed adequately to record in the said report important reservations and conditions to which your conclusions were subject and/or

(4) Produced a report that gave an unjustified impression of being independent and/or

(5) Failed to compare in the said report, or record any comparison of, Dr. Neary's rates of caesarean hysterectomy with your own rates or with those at other hospitals and/or.

(6) Failed independently to verify, whether by reference to clinical notes or otherwise, that the patients stated by Dr. Neary to have elected to have caesarean hysterectomy did in fact so elect and/or

(7) Stated in the said report that Dr Neary had no case to answer in respect of the cases reviewed in the said report when you ought to have known that Dr Neary did have a case to answer in respect of some or all of those cases and/or

(8) Stated in the said report that Dr Neary had no case to answer in respect of the cases reviewed in the said report when this was not a conclusion that could be legitimately expressed without also expressing serious reservations about some or all of the cases and/or

(9) Stated in the said report that Dr Neary should continue to work in Our Lady of Lourdes Hospital without any restrictions on his practice in circumstances where you knew or ought to have known that there were grounds for placing restrictions on Dr Neary's practice.

(10) Stated that Dr Neary should continue to work in Our Lady of Lourdes Hospital without any restriction on his practice in circumstances where that conclusion could not legitimately be expressed without also expressing serious reservations in that regard.

(11) Prepared the said report in circumstances where you ought to have known that if its contents were accepted, then the safety of future patients of Dr. Neary would be put at risk.

(12) Such further allegations as may be notified to you.

AND TAKE NOTICE that the nature of the evidence proposed to be considered at the Inquiry and the names of the witnesses whom it is the intention of the Registrar to request to be in attendance at the Inquiry for the purpose of giving evidence are to be found in the Schedule attached to and accompanying this Notice.

AND FURTHER TAKE NOTE that you or any person representing you shall be given the opportunity of being present at such hearing, of being heard and of calling evidence.

AND FURTHER TAKE NOTE that the evidence of alleged professional misconduct shall be presented to the Fitness to Practise Committee in accordance with Section 45 (3) of the Medical Practitioners Act, 1978.

AND FURTHER NOTE that any communication to the Fitness to Practise Committee in reference to this Notice should be addressed to the Registrar and should be either delivered to or left for the Registrar at the office of the Medical Council, Lynn House, Portobello Court, Lower Rathmines Road, Dublin 6, or sent by registered post to such address.

DATED this 22nd day of September, 2006
SIGNED John P. Lamont
JOHN P. LAMONT
REGISTRAR

NATURE OF EVIDENCE

Names of witnesses whom it is the intention of the Registrar to request to be in attendance at the Inquiry for the purpose of giving evidence together with a summary of the nature of such witnesses' evidence:

1) A representative of the Medical Council concerning the Report dated 5th November 1998 signed by you and the charts of the nine patients referred to in your said Report, copies of which Report and charts are sent herewith.

2) A representative of the Medical Council in respect of letters to you from the Medical Council dated 31St March 2006 and 2"d May 2006 respectively and your two letters in reply, dated 12th May and 2nd June 2006, copies of which letters are sent herewith.

3) Dr Peter McKenna in respect of the matters set out in his Report dated 30th August 2006 and the attachments referred to therein, copies of which Report and attachments are sent herewith.

4) Dr Michael Maresh in relation to the matters set out in his Report dated 3rd December 1998, a copy of which Report is sent herewith.

5) Mr Finbar Fitzpatrick in relation to his meetings and discussions with you on or around 4th November 1998 in connection with the preparation of the said Report dated 5th November 1998, the nature of whose evidence will be furnished to you prior to the commencement of the Inquiry.

6) Dr Michael Neary in relation to his meetings and discussions with you on or around 4th November 1998 in connection with the preparation of the said Report dated 5"' November 1998, the nature of whose evidence will be furnished to you prior to the commencement of the Inquiry.

7) Such other witnesses as may be notified to you.

DATED THE 22nd day of September, 2006
NOTICE OF INQUIRY

The Medical Council
Lynn House
Portobello Court Lower
Rathmines Road
DUBLIN 6

Appendix 6

Report of The Fitness to Practise Committee
following an Inquiry held pursuant to Section 45
<u>of the Medical Practitioners Act, 1978</u>

Registered Medical Practitioners: **Dr. Bernard T. Stuart - Registration No.09046**
Consultant Obstetrician and Gynaecologist,

Coombe Lying-in Hospital,
Dublin 8.

Professor W. J. Prendiville - Registration No. 15309 64
South Circular Road,
Dublin 8.

Dr. John F. Murphy - Registration No. 07253 3
Palmerstown Villas,
Dublin 6.

Dates of Inquiry: 29th November 2006

30th November 2006
lst December 2006
20th December 2006

Members of Inquiry Mr. Brendan Healy Committee:

Professor Anthony Cunningham
Professor Arthur Tanner
Dr. Miriam Hogan
Dr. Deirdre Madden

Legal Assessor: Mr. Kevin Cross S.C.

Appearances -
For the Registrar: Mr. Eoin McCullough S.C.

Mr. Patrick Leonard B.L.

- Instructed by McDowell Purcell Solicitors

For Dr. Murphy: Mr. Eugene Gleeson S.C.

- Instructed by Hayes Solicitors

For Dr. Stuart and
Professor Prendiville: Mr. Nicholas Butler S.C.

- Instructed by Arthur Cox Solicitors

Standard of Proof:

The Committee accepts that the standard of proof to be applied is the criminal standard of beyond all reasonable doubt.

Allegations of Professional Misconduct against Dr. Murphy as per Notice of Inquiry:

That Dr. Murphy, being a registered medical practitioner, failed to show and apply the standards of conduct expected by medical practitioners whilst compiling a report dated the 5t' November 1998, in respect of Dr Michael Neary's treatment and management of patients at Our Lady of Lourdes Hospital, Drogheda in that he:

(1) Prepared the said report under circumstances where he did not have adequate time or information, or alternatively did not take adequate time or procure adequate information, properly to prepare the same and/or

(2) Failed adequately to record in the said report the limitations under which the examination leading to the same was conducted and the report produced and/or

(3) Failed adequately to record in the said report important reservations and conditions to which his conclusions were subject and/or

(4) Produced a report that gave an unjustified impression of being independent and/or

(5) Failed to compare in the said report, or record any comparison of, Dr. Neary's rates of caesarean hysterectomy with his own rates or with those at other hospitals and/or

(6) Failed independently to verify, whether by reference to clinical notes or otherwise, that the patients stated by Dr. Neary to have elected to have caesarean hysterectomy did in fact so elect and/or

(7) Stated in the said report that Dr Neary had no case to answer in respect of the cases reviewed in the said report when he ought to have known that Dr Neary did have a case to answer in respect of some or all of those cases and/or

(8) Stated in the said report that Dr Neary had no case to answer in respect of the cases reviewed in the said report when this was not a conclusion that could be legitimately expressed without also expressing serious reservations about some or all of the cases and/or

(9) Stated in the said report that Dr Neary should continue to work in Our Lady of Lourdes Hospital without any restrictions on his practice in circumstances where he knew or ought to have known that there were grounds for placing restrictions on Dr Neary's practice.

(10) Stated that Dr Neary should continue to work in Our Lady of Lourdes Hospital without any restriction on his practice in circumstances where that conclusion could not legitimately be expressed without also expressing serious reservations in that regard.

(11) Prepared the said report in circumstances where he ought to have known that if its contents were accepted, then the safety of future patients of Dr. Neary would be put at risk.

Allegations of Professional Misconduct against Dr. Stuart as per Notice of Inquiry:

That Dr. Stuart, being a registered medical practitioner, failed to show and apply the standards of conduct expected by medical practitioners whilst compiling a report dated the 4t' November 1998, in respect of Dr Michael Neary's treatment and management of patients at Our Lady of Lourdes Hospital, Drogheda in that he:

l. Prepared the said report under circumstances where he did not have adequate time or information, or alternatively did not take adequate time or procure adequate information, properly to prepare the same and/or

2. Failed adequately to record in the said report the limitations under which the examination leading to the same was conducted and the report produced and/or

3. Failed adequately to record in the said report important reservations and conditions to which his conclusions were subject and/or

4. Produced a report that gave an unjustified impression of being independent and/or

5. Failed to compare in the said report, or record any comparison of, Dr. Neary's rates of caesarean hysterectomy with his own rates or with those at other hospitals and/or

6. Failed independently to verify, whether by reference to clinical notes or otherwise, that the patients stated by Dr. Neary to have elected to have caesarean hysterectomy did in fact so elect and/or

7. Stated that all of the nine cases reviewed in the said report could be justified in the prevailing situation when he ought to have known that some or all of those cases could not be so justified, and/or

8. Stated that all of the nine cases reviewed in the said report could be justified in the prevailing situation when this was not a conclusion that could legitimately be expressed without also expressing serious reservations in respect of some or all of those cases and/or

9. Stated in the said report that there was no evidence of questionable clinical judgment or faulty decision making on the part of Dr. Neary in circumstances where there was such evidence in the material available to him and/or

10. Stated in the said report that there were no grounds to suspend Dr. Neary or to place any restrictions on his practice in circumstances where he ought to have known that there were such grounds, and/or

11. Stated in the said report that there were no grounds to suspend Dr. Neary or to place any restrictions on his practice in circumstances where that conclusion could not legitimately be expressed without also expressing serious reservations in that regard and/or
12. Prepared the said report in circumstances where he ought to have known that if its contents were accepted, then the safety of future patients of Dr. Neary would be put at risk

Allegations of Professional Misconduct against Professor Prendiville as per Notice of Inquiry:

That Professor Prendiville, being a registered medical practitioner, failed to show and apply the standards of conduct expected by medical practitioners whilst compiling a report dated the 4t' November 1998, in respect of Dr Michael Neary's treatment and management of patients at Our Lady of Lourdes Hospital, Drogheda in that he:

1. Prepared the said report under circumstances where he did not have adequate time or information, or alternatively did not take adequate time or procure adequate information, properly to prepare the same and/or

2. Failed adequately to record in the said report the limitations under which the examination leading to the same was conducted and the report produced and/or

3. Failed adequately to record in the said report important reservations and conditions to which his conclusions were subject and/or

4. Produced a report that gave an unjustified impression of being independent and/or

5. Failed to compare in the said report, or record any comparison of, Dr. Neary's rates of caesarean hysterectomy with his own rates or with those at other hospitals and/or

6. Failed independently to verify, whether by reference to clinical notes or otherwise, that the patients stated by Dr. Neary to have elected to have caesarean hysterectomy did in fact so elect and/or

7. Stated that all of the nine cases reviewed in the said report could be justified in the prevailing situation when he ought to have known that some or all of those cases could not be so justified, and/or

8. Stated that all of the nine cases reviewed in the said report could be justified in the prevailing situation when this was not a conclusion that could legitimately be expressed without also expressing serious reservations in respect of some or all of those cases and/or

9. Stated in the said report that there was no evidence of questionable clinical judgment or faulty decision making on the part of Dr. Neary in circumstances where there was such evidence in the material available to him and/or

10. Stated in the said report that there were no grounds to suspend Dr. Neary or to place any restrictions on his practice in circumstances where he ought to have known that there were such grounds, and/or

11. Stated in the said report that there were no grounds to suspend Dr. Neary or to place any restrictions on his practice in circumstances where that conclusion could not legitimately be expressed without also expressing serious reservations in that regard and/or

12. Prepared the said report in circumstances where he ought to have known that if its contents were accepted, then the safety of future patients of Dr. Neary would be put at risk.

Witnesses / Evidence Heard:

The Committee has heard evidence from the following witnesses:

Dr. Michael Maresh
Dr. Peter McKenna
Mr. Finbar Fitzpatrick
Dr. Bernard Stuart
Professor Walter Prendiville
Dr. Patricia Crowley
Dr. Peter Lenehan
Dr. John F. Murphy
Dr. Malachi Coughlan

Findings of the Committee:

(a) Dr. Murphy

Having heard the evidence adduced the Committee finds, by a majority, allegations 1, 3, 5, 8, 9 and 10 proved.

(b) Dr. Stuart

Having heard the evidence adduced the Committee finds, by a majority, allegations 1, 3, 5, 9, 10 and 11 proved.

(c) Professor Prendiville

Having heard the evidence adduced the Committee finds, by a majority, allegations 1, 3, 5, 9, 10 and 11 proved.

Professional Misconduct:

(a) Dr. Murphy

The Committee finds that allegations 1, 3 and 5, as proved, do not amount to professional misconduct and by a majority that allegations 8, 9 and 10, as proved, do amount to professional misconduct as defined by Keane J. in O'Laoire v The Medical Council, being conduct in connection with his profession in which the medical practitioner has seriously fallen short of the standards of conduct expected among medical practitioners and not in a sense of any "infamous" or "disgraceful" conduct or any conduct involving any degree of moral turpitude, fraud or dishonesty.

(b) Dr. Stuart

The Committee finds that allegations l, 3, 5, 10 and 11, as proved, do not amount to professional misconduct and by a majority that allegation 9, as proved, does amount professional misconduct as defined by Keane J. in O'Laoire v T7ie Medical Council, being conduct in connection with his profession in which the medical practitioner has seriously fallen short of the standards of conduct expected among medical practitioners and not in a sense of any "infamous" or "disgraceful" conduct or any conduct involving any degree of moral turpitude, fraud or dishonesty.

(c) Professor Prendiville

The Committee finds that allegations 1, 3, 5, 10 and 11, as proved, do not amount to professional misconduct and by a majority that allegation 9, as proved, does amount professional misconduct as defined by Keane J. in O Zaoire v The Medical Council, being conduct in connection with his profession in which the medical practitioner has seriously fallen short of the standards of conduct expected among medical practitioners and not in a sense of any "infamous" or "disgraceful" conduct or any conduct involving any degree of moral turpitude, fraud or dishonesty.

Recommendations to Council:

(a) Dr. Murphy

Having regard to the findings above, the Committee recommends to Council that Dr. Murphy be admonished in relation to his professional conduct.

(b) Dr. Stuart

Having regard to the findings above, the Committee recommends to Council that Dr. Stuart be advised that should he have any reservations in any future report undertaken that these reservations should be included in his report.

(c) Professor Prendiville

Having regard to the findings above, the Committee recommends to Council that Dr. Stuart be advised that should he have any reservations ink future report undertaken
that these reservations should be included in his report.

Signed Brendan Healy
Mr. Brendan Healy - Chairman

Date 12 – 1 - 07