Neutral Citation Number: [2010] IEHC 414

THE HIGH COURT

2010 434 SP

BETWEEN

IN THE MATTER OF THE MEDICAL PRACTITIONERS ACT 2007

AND

IN PARTICULAR THE MATTER OF SECTION 75(1)

OF THE MEDICAL PRACTITIONERS ACT 2007

BETWEEN

ANDREA HERMANN

APPELLANT

AND

MEDICAL COUNCIL

RESPONDENT

JUDGMENT of Mr. Justice Charleton delivered on the 23rd day of November 2010

1. On the 1st June 2010, Dr Andrea Hermann, the appellant, had three findings of professional misconduct made against her by the Medical Council. Under s.75 of the Medical Practitioners Act 2007 ("the Act of 2007"), a registered medical practitioner against whom a sanction is imposed is entitled to appeal that decision, either as to a finding or as to the appropriateness of the sanction, or both, to the High Court. The appellant has appealed sanction only. The Medical Council suspended the appellant from practice for one year and, among other requirements ordered that she undergo a period of retraining for three years following that. Section 73 empowers the Court, on hearing this kind of appeal, to confirm the decision; to cancel and replace it with such other decision as the Court considers appropriate; to impose a different sanction; or to impose no sanction.

2. I turn first to the authorities as to how the Court should approach an appeal as to sanction alone before referring to the facts of this case and giving a decision on this appeal.

Sanctions against Medical Practitioners

3. The power of the Medical Council to impose sanctions on registered medical practitioners is set out in Part 9 of the Medical Practitioners Act 2007. In particular, ss. 71 and 72 comprehensively provide the relevant powers:-

> "71.Subject to sections 57 (6)(a) and 72 , the Council shall, as soon as is practicable after receiving and considering the report referred to in section 69 (1) of the Fitness to Practise Committee in relation to a complaint concerning a registered medical practitioner where section 70 (b) is applicable, decide that one or more than one of the following sanctions be imposed on the practitioner:
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> (a) an advice or admonishment, or a censure, in writing;
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> (b) a censure in writing and a fine not exceeding €5,000;
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> (c) the attachment of conditions to the practitioner's registration, including restrictions on the practice of medicine that may be engaged in by the practitioner;
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> (d) the transfer of the practitioner's registration to another division of the register;
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> (e) the suspension of the practitioner's registration for a specified period;
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> (f) the cancellation of the practitioner's registration;
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> (g) a prohibition from applying for a specified period for the restoration of the practitioner's registration.

> "72.(1) The Council shall, on deciding under section 71 to impose a sanction referred to in section 71 (b), (c), (d), (e) or (g) on a registered medical practitioner, specify
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> (a) in the case of a sanction referred to in section 71 (b), the amount of the fine imposed on the practitioner,
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> (b) in the case of a sanction referred to in section 71 (c), the nature of the conditions to be attached

to the practitioner's registration,

(c) in the case of a sanction referred to in section 71 (d), the division of the register to which the practitioner's registration is to be transferred,

(d) in the case of a sanction referred to in section 71 (e), the period of suspension of the practitioner's registration,

(e) in the case of a sanction referred to in section 71 (g), the period for which the practitioner is prohibited from applying for the restoration of the practitioner's registration.

(2) The Council shall not decide under section 71 to impose the sanction referred to in section 71 (f) on a registered medical practitioner on the grounds of a conviction for an offence referred to in section 57 (1)(g) unless-

(a) in the Council's opinion, the nature of the offence or the circumstances in which it was committed render the practitioner unfit to continue to practise medicine, or
(b) a conviction for such offence would render a person unable to be registered under this Act."

4. The onus of proof in this appeal remains on the Medical Council. This is notwithstanding the fact that the subject of the sanctions, Dr. Hermann, is the appellant. In re M., a Doctor [1984] I.R. 479, Finlay P. stated at pp. 483 to 484:-

> "Upon the making by a practitioner of an application to the High Court under either s. 46 or 47 to cancel a decision the Council, the onus of proving the alleged misconduct of the practitioner rests on the Council as does the onus of establishing that the decision made by the Council with regard to the appropriate penalty is correct. Notwithstanding the use of the expression "cancel the decision", in ss. 46 and 47, I am satisfied that the procedure does not constitute a mere appeal for the combined decisions of the Committee of the Council but is an entire trial of the issues involved… [T]he Council must present to the Court such evidence as it may see fit in order to discharge the onus which is upon it, first, to establish the facts which it alleges prove the misconduct, secondly, to establish that such facts do constitute misconduct and, thirdly, to support the decision it has made. The applicant is entitled to present such evidence on all these topics as he shall see fit. The Court must then, it seems to me, proceed to reach a conclusion as to whether professional misconduct has been proved."

5. The Medical Council have confined their submissions in this case to the text of the written decision imposing the sanctions that are in issue. No evidence has been called on their side. In addition, they have made brief references in written submissions, and in the course of oral submissions, to the transcript underpinning that decision. The appellant has engaged in a similar exercise, but also called two witness in addition to her own testimony. It was made clear at the outset of the hearing, however, that the appellant does not dispute the findings made against her.

6. The issue as to the appropriate approach by the court to the sanction was considered by Finlay P. in The Medical Council v. Dr. Michael Murphy, (High Court, Unreported 29th June 1994 Finlay P.). At p. 5 of that unreported judgment, he elucidated four useful principles that are applicable in cases which require a relatively severe penalty. That analysis is appropriate to this case and can usefully be regarded as of more general application:-

> "First, I have to have regard to the element of making it clear by the order [made by the High Court on appeal] to the medical practitioner concerned, the serious view taken of the extent and nature of his misconduct, so as to declare him from being likely, on resuming practice to be guilty or like or similar misconduct. Secondly, it seems to me be an ingredient though not necessarily the only one that the order should point out to other members of the medical profession the gravity of the offence of professional misconduct and thirdly, and this must be some extent material to all these considerations, there is the a specific element of the protection of the public which arises where there is misconduct and which is, what I might describe as the standard in the practice of medicine. I have as well an obligation to assist the medical practitioner with as much leniency as possible in the circumstances."

7. This statement, made under the predecessor of the current legislation, continues to be correct as it accords with the principles set out in the Act of 2007. It is clear in terms of s. 71 that having inquired into a complaint against a doctor, the Medical Council, in considering the report of the Fitness to Practice Committee charged with that task, is entitled to grade its response on a basis akin to sentencing in criminal cases. In some instances of professional misconduct, all that may be required is advice or admonishment. At the next level a fine may be imposed to mark the seriousness of the conduct, not exceeding €5,000, and an appropriately worded censure may be recorded in writing. Where the nature of the misconduct is such that a doctor has been shown to lack sufficient competence, or where otherwise the Medical Council is concerned about the continuance of practices by the doctor that led to the finding, it may attach conditions to the registration of a doctor. This includes circumscribing the nature of the practice that may be engaged in; for instance, that the doctor should no longer perform particular kinds of operation, or should only do so in conjunction with another practitioner. The power vested in the Medical Council under the legislation to transfer a doctor's registration to another division of the register indicates that in some serious instances a medical practitioner should no longer be entitled to be regarded as a specialist in a particular area but must move, for instance, to a less exacting form of medical practice. In the most serious cases, the Medical Council can suspend the registration of a doctor, without which practice is impossible, for a specified period. In this instance, gradations are possible from a relatively brief suspension of a matter of a month or two to mark the seriousness of the misconduct in question, to a substantial suspension of a year or more where this is considered to be appropriate. Finally, the registration of a medical practitioner may be cancelled. Under s. 82 of the Act, the Medical Council may "at any time" decide to remove any conditions that are attached to the registration of the doctor. It follows from s. 71(g) that a medical practitioner whose registration is cancelled may also be prohibited for a specified period from applying for the restoration of registration. Someone who is qualified as a medical practitioner may be registered under s. 45 of the Act. Registration can involve a classification into the general division, the specialist division, the trainee specialist division or registration of an internship in the trainee specialist division. Additional qualifications may be registered under section 51. Where a medical practitioner is qualified, and is removed from the register, they may apply for re-registration under these sections and a refusal of registration can be appealed to the High Court. An application to the Medical Council can be made by a medical practioners who is subject to suspension or a change of registration for restoration.

8. A reading of the Act makes it clear that the purpose of the Fitness to Practice Committee of the Medical Council is to enquire into claims of misconduct and insufficiency of competence by medical practitioners. Complaints are made, in the first instance to the Preliminary Proceedings Committee. A complaint can be made both by another medical practitioner, by a member of the public and by the Medical Council. The complaints can involve a number of grounds. These include professional misconduct; poor professional performance; a relevant medical disability; failure to comply with a condition of registration; a failure to comply with an undertaking

not to repeat a form of misconduct or to engage in professional retraining or consent to undergo medical treatment under s. 67; violating the Act itself, or regulations made under it; and conviction for an indictable offence or the equivalent outside the State. In s. 2 of the Act reference is made to the nature of poor professional performance referred to in section 57(1). This category of misconduct was introduced for the first time in the Act of 2007. It means a failure to meet the standards of competence in knowledge and skill, or the application of knowledge and skill, or both, that could reasonably be expected of a medical practitioner practising medicine of the kind relevant to the doctor about whom a complaint is made.

9. The scheme of the Act therefore involves, in its mildest form, correction as a first gradation. In such cases the Medical Council may admonish or fine a doctor or issue a written censure. Some of these incidents may involve bringing a doctor to his or her senses. It is clear that there is an overlap in the more serious of these milder cases with the necessity to mark in an appropriate way the nature of the misconduct or lack of competence through attaching conditions to registration, and restricting the practice by the doctor of medicine. These restrictions can include a requirement for retraining, perhaps coupled with an undertaking not to practice during that time. Where a doctor is shown not to be dependably safe in the practice of one form of medicine a transfer to another division is appropriate. This kind of response rarely if ever overlaps with the earlier division and moves into the most serious category of cases where a suspension of registration, cancellation of registration and a prohibition for a substantial time against a practitioner applying for re-registration can be involved. I see no reason why in the most serious cases that this cannot be a lifetime ban on the practice of medicine. Correction, rehabilitation and punishment mark out the potential approaches by the Medical Council within these three major but sometimes overlapping categories of appropriate response to misconduct or lack of competence. To rigidly divide these responses into categories would be to undermine the scheme of the Act whereby the Fitness to Practice Committee, in making a recommendation to the Medical Council, and the Council itself, are entrusted with the important task of ensuring that the practice of medicine delivers its expected service to the public through being highly competent, safe and reliable. In the mildest cases of admonishment little danger may be involved to the public. When that category shades into the instances where it is necessary to issue a censure in writing, or to attach conditions to registration while restricting the practice of medicine that may be engaged by the practitioner, the category of misconduct or lack of competence has become more serious. It is clear from the scheme of the Act of 2007 that the approach by the Medical Council should involve protecting the public and reassuring them as to the standards that medical practitioners will at all times uphold; requiring that medical practice is by those who are properly trained and appropriately qualified to safely engage in the areas of medicine where they hold themselves out to be experts. In that and the other more serious category, the protection of the public is paramount to the approach of the Medical Council. The reputation of the medical profession must, in those instances be upheld. This exceeds in importance, where the misconduct is serious, the regrettable misfortune that must necessarily be visited upon a doctor.

The approach of the High Court on appeal

10. The question arises as to what test should the court apply to the issue of sanction where that issue alone is appealed to the court under s. 75 of the Act? It is urged that some form of curial deference should be exercised by the High Court towards decisions of the Medical Council. The Fitness to Practice Committee of the Medical Council is a specialist body dealing with complaints of professional misconduct on a frequent basis. The members of the Committee have ready access to relevant precedents and are therefore in a position to assess both the nature of the conduct complained of, and where it fits as to category, gravity, and the type and severity of penalty that has been established as appropriate by prior decisions. I have no doubt that the Medical Council should take this approach as a general guide to the imposition of penalties. I am also satisfied that it is not the only principle which is applicable. Guidelines derived from previous sanctions establish both an appropriate level of knowledge among members of the Medical Council and also informs medical practitioners and their legal representatives as to what kind of sanction may be faced in an event of a finding being made of misconduct. That, while an appropriate guide, is not completely restrictive. No court exercising a sentencing jurisdiction ever regards itself as boxed in by sentencing precedent. Exceptional circumstances can arise which move one category of case from a particular band of gravity into a higher or lower category. Mitigation of circumstances should be considered to see if some particular factor lessens the gravity of the appropriate response. Consistency of appropriate sanction against medical practitioners is, however, important for the reasons which I have mentioned and to ensure the continued trust of the public in the medical profession; one of the fundamental purposes inherent in the relevant sections of the Act of 2007.

11. In Marinovich v. General Medical Council [2002] U.K.P.C. 36, Lord Hope of Craighead, giving the judgment of the Privy Council, was of the opinion that curial deference should be uppermost in the mind of any court or appellate tribunal considering an appeal as to sanction. At paras. 28 and 29 he stated:-

> "28. In the appellant's case the effect of the Committee's order is that his erasure is for life. But it has been said many times that the Professional Conduct Committee is a body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the Committee in the light of its experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession. 29. That is not say that [the appeal body] may not intervene if there are good grounds for doing so. But in this case their Lordships are satisfied that there are no such grounds. This was a case of such a grave nature that a finding that the appellant was unfit to practise was inevitable. The Committee was entitled to give greater weight to the public interest and to the need to maintain public confidence in the profession and to the consequences to the appellant of the imposition of the penalty. Their Lordships are quite unable to say that the sanction of erasure which the Committee decided to impose in this case, while undoubtedly severe, was wrong or unjustified."

12. This decision was made, however, under legislation that differs from that in force in this jurisdiction. Having taken the principles that I have referred to into account, and having considered the role that sanctions against medical practitioners fits within the scheme of complaint enquiry, finding and response inherent in the Act of 2007, I have to come to the view that the High Court, considering an appeal under s. 75 of the Act, is deliberately vested by the Oireachtas with powers of such an amplitude that it is required to exercise its own analysis of whatever evidence as to sanction is put before it. The Medical Council retains the burden of proving that the sanction was correct. The Court, in considering whether to cancel the relevant decision, to replace it with a different decision or to impose no sanction on the practitioner, is obliged to assess what is appropriate in light of the findings of fact which led to the imposition of the sanction by the Medical Council in the first instance. That decision, and the reasoning underpinning it, should not be ignored. Rather, that decision and the justification contained within the document imposing the sanction is the primary material under appeal and on which the hearing is based. In considering the question of the sanction, the Court's focus should be both on the conduct underpinning the sanction and the reasoning of the Medical Council in arriving at its decision. Because of the relatively greater experience of the Medical Council in imposing sanctions, its knowledge as to relevant precedents and the expert nature of the task undertaken, the High Court, on an appeal as to sanction, should treat the decisions of the Medical Council with respect. An independent view should be taken as to what ought to be done. Where an error has been made in the context of a sanction which is otherwise appropriate, then it should be corrected. If, however, the level of sanction is one which is justified by the material before the Medical Council, then the Court would need to find a specific reason for altering it on the evidence presented on the appeal.

Conduct in issue here

13. The appellant holds both general and specialist qualifications. Her specialist qualifications include a MD, a fellowship of the Royal College of Gynaecologists and a Fellowship of the Royal College of Surgeons in Ireland. She has carried out over 2,600 procedures as a specialist gynaecologist and was the only gynaecologist working in the Galway clinic for some years prior to these incidents occurring. On 18th November 2008, she was suspended from practice by the Galway clinic. On the 28th August 2009, a complaint was formally made to the Fitness to Practice Committee of the Medical Council. An enquiry took place between the 6th October 2009 and the 8th February 2010 over fourteen days of hearing. Final submissions were made on the 19th April 2010. The Fitness to Practice Committee made a report to the Medical Council on the 14th May 2010. On the 1st June 2010 the Medical Council made a decision in respect of the appellant which was notified to her by a letter dated 4th June 2010. Whereas complaints were made in relation to eight patients, the sanctions eventually imposed were in respect of only three where findings of misconduct had been made. These will be referred to as patients 1, 2 and 8.

14. It is clear that the Medical Council regarded this case overall as being in the most serious category of professional misconduct and poor professional performance. The letter announcing the response to Dr Hermann cites as a reason for the Council's decision "the severity of the finding of professional misconduct made against" the appellant. The operative part of its decision, as notified in that letter, reads:-

> "The Council has instructed me to inform you that it has decided to invoke its powers under s. 71(e) of the Medical Practitioners Act 2007, and your name be suspended from the Register for a period of twelve months.
>
> The Council further decided to invoke its powers under Section 71(c) of the Medical Practitioners Act, 2007, and attach the following conditions to the retention of your name in the Register maintained by the Council under the Act following the period of suspension.
>
> (i) Immediately upon your return to practice you must work with a nominated person acceptable to the Medical Council to formulate a professional development plan specifically designed to address the deficiencies in the following areas of your practice.
>
> (a) Gynaecological surgical techniques.
>
> (b) Clinical decision making.
>
> (c) Collaboration and team working.
>
> (ii) You must forward a copy of your professional development plan to the Medical Council
>
> (iii) You must meet with a nominated person acceptable to the Medical Council, on a regular basis to discuss your progress towards achieving the aims set out in your professional development plan. The frequency of your meetings is to be agreed by the nominated person and the Medical Council.
>
> (iv) You must agree to the nominated person acceptable to the Medical Council supplying reports to the Medical Counsel about your progress when requested.
>
> (v) You must provide evidence to the Medical Council of your on-going and regular participation in relevant continuing professional development.
>
> (vi) On the completion of your period of suspension you must confine your medical practice to working in hospitals in which there are at least two other gynaecologists who are on the Specialist Register.
>
> (vii) You must confine your medical practice to a recognised training post where your work will be supervised by a named consultant, acceptable to the Medical Council.
>
> (viii) You must be responsible for discharging all costs associated with the implementation and compliance with these conditions.
>
> (ix) These conditions will remain in place for a minimum of three years."

15. Evidence was given on behalf of the appellant by Dr. Syed Jaffry. He had assisted in relation to the treatment of patient 2, whose case I will turn to shortly. He is a consultant urologist of high standing. He regarded the appellant's skill as a gynaecologist as being on a par with the best in the West of Ireland. He did not find her to be a danger to any of her patients. From 2006 to 2008 he operated together with the appellant on two to three cases per week. Dr. Peter Boylan, a distinguished obstetrician, analysed the case on behalf of the appellant and gave evidence both before the Court and before the Medical Council. He did not regard the appellant as a danger to the public. He said that she would benefit from training under a consultant for a year. It would be impossible, according to Dr. Boylan, for the appellant to obtain a specialist training post. He regarded training under a busy consultant in a busy unit for a year as being a sufficient rehabilitation, together with an audit of her work being submitted to the Medical Council on a regular basis over that year, or perhaps over a further brief period. The appellant also gave evidence. She said that she accepted that her conduct fell seriously below the standard of a consultant gynaecologist. That acceptance was reluctant. She described her attitude to the finding as one which saddened her. The appellant explained the case of patient 8, to which I will shortly turn, as being explicable by reason of upset at having had a complaint made against her to the Medical Council in the first instance, and an inability to cancel operations because patients had already been booked in, coupled with the loss of her mother, who was very sick in Germany on the weekend in question. She also described life since the findings of the Medical Council. It is fair to say that this has been difficult.

16. I accept the evidence of Dr. Jaffry and Dr. Boylan. That evidence has to be seen, however, within the context of the misconduct found as a matter of fact, following a full analysis of the evidence, by the Medical Council. As regards the sanction, the evidence of Dr. Boylan is clearly correct to the effect that the appellant will not be able to be admitted to a specialist training post. In consequence, that aspect of the decision of the Medical Council requires correction. The ultimate issue as to the appropriateness of the sanction is, however, to be approached on the basis of the treatment of the three patients. I turn to these now.

Patient 8

17. On the 21st October 2008, patient 8, who was then aged 63 years, was referred to the appellant. She had, some five years

previously, had a complete hysterectomy and bilateral salpingo-oöphorectomy with a Burch colpo-suspension. She was troubled with symptoms of prolapse. The appellant decided on an operation to repair the bulging into the vagina of patient 8. This was to consist of a colpopexy combined with enterocle repair. That operation was carried out on the 14th November 2008. The patient recovered consciousness as normal but began complaining of severe pain, despite morphine and other drugs. The appellant saw her at midday and prescribed pethidine. Deterioration followed through the early morning of the next day. This involved clear findings of low pressure, low oxygen saturations and led to alarm. As I understand it, it was not consistent with the etiquette in the Galway Clinic that another doctor should take over treatment at this point. At 05.15 hours a call was made to the appellant. She did not answer. A message was left on her answering machine indicating the level of concern in question. The appellant did not contact the hospital. The patient became weaker. At 09.00 hours there was another telephone call to the appellant, who lived within an half an hour of the hospital but she did not answer the phone. At 09.15 the appellant phoned the hospital and was filled in on the relevant findings. She advised tests, including blood tests. She did not indicate that the blood tests were urgent nor did she request an X-ray of the abdomen. At 13.00 hours the appellant asked for the result of the blood tests. They were not available. At this stage the appellant indicated that she wanted the test done urgently. Two hours later the appellant was contacted with the results. She was told that the patient was extremely weak. The appellant indicated that a consultant surgeon would review the patient, but this consultant was then in Portlaoise. By 17.00 hours the family became anxious and demanded to speak to the appellant. She was contacted and indicated that she would attend within two to three hours. She saw the patient at 18.00 hours. Broad spectrum antibiotic treatment was then initiated, there had been some earlier antibiotic intervention, and further investigations were requested by the appellant. The consultant surgeon, referred to earlier, saw the patient at 21.15 hours. There had, in fact, been a different surgeon on call. He was not contacted. This surgeon suspected septicaemia arising out of a bowel perforation. He advised a laparotomy. Through the early hours of the 17th November, patient 8's condition deteriorated. The appellant was again contacted at 05.00 hours and awoken by nurses. The appellant spoke to an anaesthetist and the patient was transferred to the intensive care unit. The anaesthetist took over care and by 07.00 hours, it would seem on the next day, the patient was in a fit condition to undergo surgery. By the time of the relevant intervention there was a significant life-threatening overwhelming infection present. Following a C.T. scan, a laparotomy was decided upon. At 13.10 hours the operation revealed a small bowel perforation. I am unclear on the papers as to whether this was on the 17th or the 18th, as the C.T. scan is dated the 18th, it appears to be that day. In the result, however, it makes no difference to my approach. The damage had already been done. In the operation, the perforated area was resected and side-to-side anastomosis was performed. The patient later suffered a stroke. It is impossible to definitively relate the occurrence of the stroke to the events of the 14th to 18th November 2008. I thus take no account of this.

18. The Fitness to Practice Committee found that there was a failure by the appellant to conduct any adequate investigations or adequate examinations consequent upon the symptoms exhibited. The Committee also found there was poor professional performance and professional misconduct because of the appellant's failure to consider and act upon the advice of other doctors. They found the appellant fell seriously short of the standard of care expected, notwithstanding personal difficulties at the time. They found the appellant had failed to appreciate the gravity of patient 8's condition. The Committee also found that she had failed to carry out or arrange for appropriate surgical exploration prior to that eventually coming about. In the course of the hearing before the Fitness to Practice Committee, a view was expressed that it is surprising that patient 8 did not die. The response by the appellant was described as "unbelievable management". On the appearance of the infection, the failure to treat appropriately with antibiotics and to engage in an appropriate response initiated and continued a delay that increased serious risk to the patient.

19. It might be commented in relation to patient 8 that, of itself, this case fell within the most serious gradation of misconduct and poor professional performance. It might be possible to argue, in mitigation, that the personal situation of the appellant, her mother being ill and her desire to travel to Germany to be with her when she died, could lesson the impact of the findings of misconduct. I do not agree. The Court can see no reason for the appellant to fail to answer the phone on a number of occasions and to fail to respond promptly, knowing that the etiquette in place in Galway Clinic meant that she had primary care of the patient. The sanction imposed by the Medical Council might be somehow argued to be harsh were it not for the findings in respect of patients 1 and 2.

Patient 1

20. The issues in relation to patient 1 arose when she attended, as a 39 year old mother of two, for a consultation with the appellant in January 2005. That month the appellant wrote to the patient's G.P. indicating that she was pursuing a working diagnosis of polycystic ovarian syndrome. The appellant decided upon a diagnostic laparoscopy and treatment of unilateral ovarian diathermy. The appellant was hoping, quite reasonably, that some of the symptoms could be controlled on the destruction of ovarian stoma. Later that month a C.T. scan, first in time, and after that a diagnostic laparoscopy were carried out at the Galway Clinic. The scan report, however, removed any reason to engage in the later laparoscopy. An operation was carried out that day, although the notes are not clear on the precise procedure. It was stated to be a diagnostic laparoscopy plus left ovarian cystectomy. In the aftermath of the procedure patient 1 was sick and was detained overnight. At 09.30 hours the next day, an elevated temperature was recorded. The appellant advised that no intervention was needed. By 23.20 hours the patient developed cramps and severe abdominal pain. On 27th January at 06.30 hours the temperature of patient 1 had elevated. The appellant was noted to be on the ward at 07.15 hours but was also noted to be intending to review the patient later in the day. By lunchtime the patient had vomited and had a slightly elevated temperature. The appellant did not review patient 1 in the morning. Her explanation was that perhaps the patient had gone to the bathroom and, in consequence of a large list of which she was a part, she had been missed. As to lunchtime of that day, there is a note made by the appellant concerning patient 1. By early the next morning the situation had become critical. The appellant was contacted. At 04.45 hours the appellant phoned and advised that the theatre should be organised for an operation. A diagnostic laparoscopy was performed on the morning of the 28th January and it was decided, in consequence of it, that a laparotomy was necessary. A surgeon was called. On this procedure there was murky fluid all over the abdomen. On the 29th January the micro-biology report from the laboratory indicated the presence of group A streptococcus in the peritoneal fluid. The patient was then transferred to intensive care. She then suffered multi-organ failure, secondary to the infection, suffered a cardiac arrest and had a consequential brain injury. She was transferred to University College Hospital in Galway city. Her condition on leaving the Galway Clinic was that she never appeared to recognise her husband or children again. She died three years later.

21. The Fitness to Practice Committee noted the allegations that were admitted on behalf of the appellant. It was of the view that the clinical diagnosis of polycystic ovarian syndrome was not confirmed by ultrasound and therefore an option of conservative treatment should have been given to the patient. The findings continue:-

> "[N]o adequate investigations were carried out… adequate records of treatment were not adopted, although the latter was not a serious falling short in the standard expected among doctors. Appropriate antibiotics were not administered at the appropriate time and Dr. Hermann failed to seek the opinion of surgical colleagues. It is hard to appreciate the gravity of a patient in [patient 1's], but Dr. Hermann failed to do so and Dr. Hermann clearly failed to carry out any appropriate surgical exploration before 27th January 2005, and failed accordingly to apply the appropriate standards of judgement in respect of the care afforded to the patient. The Committee noted that in relation to the question of misconduct that this

was admitted by Dr. Hermann [apart from an allegation that was not proved and two others which do not professional misconduct]. Each of the other allegations as proved do amount to a serious falling short by Dr. Hermann of the standards expected among doctors."

22. The view specifically accepted by the Committee was that put before the Committee by Professor John Bonner. It was central to the findings of the Committee and not contested on behalf of the appellant on this appeal. It was that there should have been intervention early on the morning of the 27th January, and not on the next day. As to this, Professor Bonner stated:-

> "At 6.30 her temperature was 39.1. Dr. Hermann was in the ward at 7.15. I would have expected her to go and see the patient… [who was] someone who is in as a day case, she is now in two days late, she has been very sick during the night, she is requiring powerful analgesia. She is in pain. She has got a high temperature. I would have thought that the detailed assessment should have been done at 7.15, and the antibiotics should have been started, the theatre should have been organised, and a consultant surgeon should have been brought in make his individual assessment and a joint laparotomy would be done by the gynaecologist and the surgeon, probably by mid-morning at the latest."

23. I have also reviewed the written submissions as to this case lodged on behalf of the appellant. No matter how one looks at the case there is a serious falling short of the standard to be expected of a consultant gynaecologist. It is appropriate to note the level of concern among the nursing staff and the failure by the appellant to review the patient, in this context, whether due to an error or the absence of the patient momentarily, in the bathroom, as very serious. This case is again in the upper range of misconduct contemplated in relation to the sanction provisions of the Act.

Patient 2
24. Patient 2 was a 63 year old lady with a history breast cancer. In June 2006 an ultrasound examination was arranged by her general practitioner. The result was a finding of an ill-defined hypoechoic lobulated structure on the left side of the uterus. It was possible this was either in an attached bowel loop, a left adnexal mass or a multi-fibroid uterus. The patient was then referred on to a consultant obstetrician at Mayo General Hospital and to a specialist gynae-oncologist. An MRI scan was carried out on the 18th July 2006 and a report was issued indicating:-

> "Large lobulated solid T1 and T2 ISO intense mass lesion as described which overall has neoplastic appearances. It is invading the corpus uteri and cervix as well as displacing the bladder and rectum. Its epicentre is in the region of the left adnexum and is locally aggressive. Given the background history of breast carcinoma, the possibility of Krukenburg tumour should be considered and the differential diagnosis includes unusual presentation of primary ovarian neoplasan or leiomyosarcoma of the uterus".

25. Confusion between the specialists then followed. The family doctor of patient 2 was aware that the specialist at Mayo General Hospital was going on holidays for three weeks. He was of the view that this was an urgent case. He was unaware, apparently, that the patient had been referred on to a specialist gynae-oncologist. Thus he referred the patient to the appellant. In the referral letter he referred to the findings as "very sinister indeed".

26. On examining the patient, however, the appellant indicated that the signs were of a "benign gynaecological condition and I had a suspicion that we are dealing here simply with a fibroid uterus". On the 2nd August patient 2 attended her consultant medical oncologist, who was following up on her treatment for earlier breast cancer. He wrote to the appellant indicating that although the lesion on the C.T. scan looked like a predunculated fibroid, the MRI scan was more suggestive of a malignant process. There were very strong indications on this basis, the Fitness to Practice Committee found, that the patient had a cancerous process. On 17th August 2006 when the appellant operated on patient 2, a large adherent tumour was found. This was outside the areas of expertise of the appellant. A general surgeon was ten minutes away but the appellant chose instead to ask for a surgeon who might have reasonably been expected to attend after about an hour, but who in fact could only attend an hour and half later. The appropriate treatment, following discussion between the appellant and that surgeon, was for the patient to be closed, for radiotherapy to be initiated followed by an MRI scan and, when the tumour was shrunk, to operate again. This is what happened. Later, on the 8th December 2006 the appellant operated on patient 2 by way of a re-laparotomy and removed the tumour.

27. The Fitness to Practice Committee found that the appellant should have referred patient 2 to a gynae-oncologist. There was a suspicion, it seems to the Court a very strong one, that cancer was involved. In the circumstances, the appellant was acting outside her area of expertise in operating as outlined on 17th August. The Fitness to Practice Committee found that the appellant did not have sufficient experience or training to treat the condition. An explanation was given by the appellants as to the calling of the general surgeon and as to why the surgeon, who was closest, in terms of time, was not involved in the case. The Committee rejected that explanation. Having listened to the appellant I would say that I have a reasonable doubt in that regard. The appellant indicated that if she had not acted as she did, patient 2 might have been kept waiting for a proper examination by a gynae-oncologist; meaning to get an appointment. At the time in question, there had been one in Galway, but he had recently retired. The patient had a good outcome ultimately.

28. The appellant did not challenge the findings of the Fitness to Practice Committee. This was a case that could be regarded as falling into the category of moderately serious professional misconduct. The fact of recovery, and a potentially worse outcome had there been delay, is offered in mitigation. That, in the instance of patient 2 might reasonably be accepted and might mean that a penalty more towards the lower end of the appropriate scale in the medium bracket could have been imposed. It is only one case out of three, however.

Comment
39. Given the culmination of the factors which led to the findings against the appellant in respect of patients 1, 2 and 8, the case is placed very firmly within the most serious category of professional misconduct. The Medical Council have proven that the penalty imposed was not disproportionate. Having reviewed the evidence before the Fitness to Practice Committee, and having heard evidence on the appeal, my view of the case does not differ from that of the Fitness to Practice Committee. In reaching this conclusion, I also have regard to the expertise of the Council and its wide experience of these cases.

Mistake
30. The Court accepts, however, that the decision of the Fitness to Practice Committee on the 1st June 2010 contains an error. There is no recognised training post which is open to the appellant and that mistake justifies this appeal. In consequence, condition (vii), quoted above at para.15, whereby the appellant was required to confine her medical practice to a recognised training post where her work would be supervised by a named consultant acceptable to the Medical Council, must be altered. Instead, by order of the Court, the appellant is to work in a post where for three years she will be under the supervision of a named consultant acceptable to the Medical Council. All the other conditions remain in place, including her suspension from practice for a period of one year from

the 1st June 2010.

Result
31. In the result, the penalty imposed by the Medical Council was proportionate and justified by the circumstances. The rehabilitative measures proposed are sensible. The alteration that is required in the conditions for return to practice continues to recognise that supervision over a period of three years is a proportionate rehabilitative and punitive response to the findings against the appellant.