O'CONNOR SOLICITORS

CORBALLY – THE IMPLICATIONS

1. INTRODUCTION

Corbally v The Medical Council and Ors [2015] IESC 9 is perhaps one of the most significant cases in the area of professional regulatory law to be considered by both the High Court and Supreme Court in recent years.

Before considering the decisions of the High Court and the Supreme Court in *Corbally*, it is first necessary to look at the facts that gave rise to the complaint to the Medical Council against Professor Martin Corbally.

2. THE FACTS OF *CORBALLY*

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

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

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

On the 11th March 2010, Professor Corbally booked the patient in for her procedure and correctly completed an admissions form for the patient, listing her for a *"tongue tie (upper frenulum)"*. The procedure was to be performed as a day case on the 30th April 2010. The admissions form was sent to the admissions department where the patient's details and the proposed procedure were entered into the patient administration system. Unfortunately the reference to the upper frenulum, through no fault of Professor Corbally, was not inputted into the hospital system. The reason for this was that the system as it then operated in Crumlin had one code only for all frenula dissection, all three types being described as *"tongue tied"*. That being so the operation was inputted in the system as *"tongue tie release"* without the addition of the words *"upper frenulum"*.

Following her admission on the 30th April 2010, the patient's parents provided and furnished a consent to the procedure to the senior house officer, Dr. A.J. Orafi, for a *"tongue tie – upper frenulum release"*. In the account of the consent process furnished by the mother of patient X, she maintained that when Dr. Orafi started to describe her daughter's case as a *"tongue tie procedure"*, she corrected the doctor by saying that it was her daughter's upper lip that needed a release and not her tongue. Dr. Orafi apparently stated that the procedure would still be called a tongue tie. However, on the consent form the procedure was clearly

described as *"tongue tie (upper frenulum) release"*. This pre-operative conversation took place in the presence of one of the nursing staff, Nurse Pollard, but it appears that this particular detail, for whatever reason, was not passed on to the surgical team in accordance with the *"Correct Site Surgery Policy"*. Dr. Orafi was due to be present at the operation but in fact was diverted elsewhere.

Professor Corbally had intended to perform the surgery himself, however he was called as a matter of urgency to attend to another patient in the intensive care unit. His specialist registrar, Dr. Farhan Tareen, was delegated by him to perform the procedure. Professor Corbally asked Dr. Tareen in the hospital corridor what was happening with the theatre list, reviewed it and asked Dr. Tareen to perform the tongue tie. Professor Corbally said that he delegated the procedure by referring to the description on the theatre list.

The hospital at the time had a protocol for a *"surgical pause/time out"* procedure in advance of the commencement of surgery. Dr. Tareen, the anaesthetist and the nursing staff were present at the surgical pause. The purpose of the surgical pause is to undertake and complete a check to ensure that the correct patient is listed for the correct procedure at the correct site.

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

Unfortunately, Dr. Tareen carried out a lingual frenulectomy, which was an unnecessary procedure and one which, having been carried out, left the patient still requiring the upper frenulum release which was undertaken when the child was brought back to theatre that same day. The second procedure was uneventful and the child made a full recovery after a short period of pain and discomfort from the original lingual frenulectomy and suffered no ongoing disability as a result of the unnecessary operation which was performed.

The parents of Patient X lodged a complaint with the Medical Council on the 4th September 2010 against Professor Corbally and his colleague Dr. Tareen. However, charges against Dr. Tareen were not pursued.

At the outset Professor Corbally admitted that his wording of the procedure in his original notes was inaccurate and made a full and comprehensive apology to the parents of patient X. A completely new protocol for such procedures was devised and put into place at Crumlin hospital so as to ensure that no such confusion or mistake could ever again occur.

3. ALLEGATIONS AGAINST PROFESSOR CORBALLY AND FINDINGS

Following receipt of the complaint from the parents of patient X, the Preliminary Proceedings Committee of the Medical Council formed the opinion that there was a *prima facie* case to warrant further action being taken in relation to the complaint and referred same to the Fitness to Practise Committee of the Medical Council. The Fitness to Practise Committee decided to hold an Inquiry at which some eight allegations of Poor Professional Performance were advanced. At the hearing, the majority of the allegations were withdrawn, but the Fitness to Practise Committee made three specific findings against Professor Corbally as follows:-

Allegation number 1:
That on or around 25th February, 2010 Mr. Corbally incorrectly described the procedure required for patient X in her medical records as excision of 'upper lingual frenulum'.

Having regard to the evidence adduced, the Committee found that Allegation 1 was proven as to fact and that it did amount to Poor Professional Performance on the part of Professor Corbally. By a majority, the Committee stated that it was satisfied beyond reasonable doubt that the allegation constituted Poor Professional Performance on the basis of the expert evidence given by Mr. Hugh W. Grant (the expert called on behalf of the Medical Council) and notwithstanding the expert evidence to the contrary given by Mr. Kieran O'Driscoll (the expert called on behalf of Professor Corbally).

The Committee noted that the wrong diagnosis was recorded in circumstances where Professor Corbally had a responsibility to accurately document the problem and planned surgical procedure. A minority view of the Committee was that this entry did not influence the booked hospital procedure and therefore did not constitute Poor Professional Performance.

Allegation number 6:
That on or around 30th April, 2010, Mr. Corbally delegated patient X's surgery to Dr. Fahran Khaliq Tareen ("Dr. Tareen") in circumstances where he failed to communicate adequately or at all to Dr. Tareen the procedure to be performed on patient X.

The Committee found that Allegation 6 was proven as to fact and that it did amount to Poor Professional Performance. The Committee stated that it was satisfied that this allegation constituted Poor Professional Performance on the basis of the expert evidence given by Mr. Grant and notwithstanding the expert evidence to the contrary given by Mr. O'Driscoll.

Both expert witnesses agreed that Professor Corbally was entitled to delegate this procedure to a qualified colleague. However, Mr. Grant's view convinced the Committee that he also had a responsibility to issue the correct instruction when making the delegation. This responsibility existed notwithstanding the pressures of work as set out by Professor Corbally.

The Committee further stated that the known weaknesses in surgical systems at the hospital, such as the absence of team briefings before surgery commences and the absence from theatre (on occasion) of the doctor who has consented the patient/parents, only served to increase the responsibility on a senior surgeon to communicate adequately when delegating a procedure to a junior doctor.

Allegation number 8:
That Mr. Corbally failed to apply the appropriate standards of clinical judgement that could be expected from a surgeon with your experience or expertise.

The Committee found that Allegation 8 was proven as to fact and that it did amount to Poor Professional Performance. The Committee stated it was satisfied that this constituted Poor Professional Performance on the basis of the expert evidence given by Mr. Grant and notwithstanding expert evidence to the contrary given by Mr. O'Driscoll.

The Committee had regard in particular to the evidence that this procedure was rarely carried out in the hospital and that the surgical booking/coding system was known to be incapable of coding a procedure such as division of the upper lip frenulum. In these circumstances, Professor Corbally had a particular responsibility to ensure that all necessary precautions were taken to ensure that the patient received the correct surgery. The

Committee were of the view that his failure to do so, by relying on systems known or suspected to be flawed, constitutes poor clinical judgement.

It should be noted that the Committee also considered that it was appropriate to specify that the Inquiry had thrown up significant evidence of systems failures at Crumlin hospital and they recommended that the Medical Council pursue these. Their concerns focussed specifically on inadequate surgical booking/coding systems, the lack of implementation of the hospital's own *"correct site surgery"* policy and failure to effectively implement the surgical pause procedure, coupled with weaknesses in communication and leadership.

In relation to Professor Corbally, the Committee recommended to the Council that it impose the sanction of admonishment or censure, offering the following reason for doing so:

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

The Council thereafter considered the report from the Fitness to Practise Committee and decided, under the provisions of Section 71(a) of the Medical Practitioners Act 2007 (as amended) to admonish Professor Corbally.

4. HISTORY OF POOR PROFESSIONAL PERFORMANCE

Before turning to the decisions of the High Court and the Supreme Court, it is necessary to first look at the legislative background and previous caselaw.

The Medical Practitioners Act 2007 (the 2007 Act) replaced the Medical Practitioners Act 1977 and for the first time introduced the concept of *"Poor Professional Performance"* which is defined in Section 2 of the 2007 Act as follows:

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

Previously the main ground for complaint against a medical practitioner was *"Professional Misconduct"* which was not defined in legislation but rather had been interpreted by caselaw over the years. To fully understand Poor Professional Performance it is first necessary to look at Professional Misconduct.

The leading Irish case in relation to Professional Misconduct is ***O'Laoire v The Medical Council*** (unreported), High Court, 27 January, 1995. This case dealt with the interpretation of Professional Misconduct under the Medical Practitioners Act, 1977. As Keane J. noted:

"The expression of 'professional misconduct' is not defined in the Act. Its meaning, and that of corresponding expressions which appeared in earlier legislation, has however been considered in a number of authorities in Ireland and England……".

Mr. Justice Keane referred to ***Re Lynch and Daly*** [1970] I.R. 1, which was a veterinary case, but the statutory regulation was in similar terms. Keane J. noted that the practitioner, in order to be sanctionable, had to be *"guilty of conduct disgraceful to him in a professional respect"*. Keane J. went on to cite with approval ***Alinson v General Council of Medical***

Education and Registration [1894] 1 QB 750 where the corresponding term was *"infamous conduct in a professional respect"*.

Justice Keane also cited ***Felix v General Dental Council*** [1960] AC 704 which referred to *"infamous disgraceful conduct in a professional respect"* and observed that it was *"not enough to show that some mistake had been made through carelessness or inadvertence in two or even three cases out of four hundred and twenty-four patients"* but that *"some element of moral turpitude or fraud or dishonesty in the conduct complained of, with such persistent and reckless disregard of a dentist's duty in regard to records as can be said to have amounted to "dishonesty" was required for this purpose."*

Turning again to ***Alinson***, Keane J. stated that:

"[The misconduct] fell to be judged in relation to the accepted standards of his profession".

Keane J. quoted the judgement of Lord Jenkins in ***Alinson*** as follows:

"These two adjectives nevertheless remain as terms denoting conduct deserving of the strongest reprobation, and indeed so heinous as to merit, when proved, the extreme professional penalty of striking of".

Keane J. next noted the change in the statutory terminology in England from *"infamous or disgraceful conduct in a professional respect"* to *"serious professional misconduct"*. The significance of this is illustrated by Lord Mackay in his judgment in ***Doughty v General Dental Council*** [1987] 3 AER 843. Keane J. quoted the following passage from that case:

"The Lordships regularly accept that what was infamous or disgraceful conduct in a professional respect would also constitute serious professional misconduct but they consider that it would not be right to require the Council to establish that the conduct complained of be infamous or disgraceful and that therefore it would not be right to apply the criteria which Lord Jenkins derived from the dictionary definitions of those words……".

Having considered the above caselaw, Mr. Justice Keane made following comments:

"From these authorities, I think, that the following principles can be deduced:

(1) Conduct which is 'infamous' or 'disgraceful' in a professional respect is 'professional misconduct' within the meaning of S.46(1) of the [1977] 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 either to his patients or to his colleagues, may be regarded 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 amongst medical practitioners.

(6) I do not attach any significance to the fact that the adjective 'serious' does not appear before 'professional misconduct' in S.46(1)(8) and (unlike the provision under consideration in ***Doughty****). Only conduct which seriously falls short of the accepted standards of the profession could justify a finding by the professional colleagues of a doctor of 'professional misconduct' on his part.*

(7) 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……".

The above often quoted judgment of Justice Keane is the common law definition of Professional Misconduct as it applies to medical practitioners and indeed other regulated professions where there is no statutory definition of Professional Misconduct provided for in their governing legislation.

Unlike Professional Misconduct as set out above, prior to *Corbally* there were no caselaw in relation to the interpretation of Poor Professional Performance. However, there did exist English caselaw that considered the equivalent term of *"deficient professional performance"* which Kearns J in the High Court in *Corbally* found to be of assistance in defining Poor Professional Performance.

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

"Section 35C(2) – A person's fitness to practise shall be regarded as 'impaired' for the purpose of this Act by reason only of –

(a) misconduct;

(b) deficient professional performance"

in ***R. (Calhaem) v The General Medical Council*** [2007] EWHC 2606 (Admin), Justice Jackson dealt with the English formulation of *"deficient professional performance"*. Jackson J. reviewed the authorities and derived five principles as follows:

"From this review of the authorities, I derive five principles which are relevant to the present case:

(1) Mere negligence does not constitute 'misconduct' within the meaning of S. 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending on the circumstances, negligent acts or omissions which are particularly serious may amount to 'misconduct'.

(2) A single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions. Nevertheless, and depending on the circumstances, a single negligent act or omission, if particularly grave, could be characterised as 'misconduct'.

(3) 'Deficient professional performance' within the meaning of S. 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute 'deficient professional performance'.

(5) It is neither necessary nor appropriate to extend the interpretation of 'deficient professional performance' in order to encompass matter which constitute 'misconduct'."

It is against the above background that the Professor Corbally's case fell to be considered by both the High Court and the Supreme Court.

5. JUDICIAL REVIEW IN THE HIGH COURT

While the sanction of admonishment is one of the least serious of the sanctions provided for by Section 71(a) of the 2007 Act, it still represents a serious sanction from a medical practitioner's point of view as it is usually notified to the public and any other registration authority where the medical practitioner might be working.

Professor Corbally did not accept the findings of the Fitness to Practise Committee but as there was no appeal mechanism in relation to the sanction of admonishment, he was obliged to have recourse to the relatively technical remedy of judicial review. If a more serious sanction such as striking off or suspension, or the attachment of condition to his registration had been imposed, Professor Corbally would have had available to him an appeal on the merits rather than through judicial review.

When the judicial review proceedings came to be considered by Justice Kearns in the High Court, the central and critical questions were as follows:

(a) What constitutes "Poor Professional Performance" as provided for by the 2007 Act?

(b) Can a single error in writing up patient notes constitute Poor Professional Performance?

(a) Poor Professional Performance

In considering what constituted Poor Professional Performance, Justice Kearns had regard to the applicable English statutes and caselaw as referred to above.

In particular he was of the view that the third and fourth principles as set out by Justice Jackson in **R. *(Calhaem) v General Medical Council*** were the appropriate principles for construing the definition of Poor Professional Performance under Section 2 of the 2007 Act.

Justice Kearns was of the view that given that the 2007 Act provided that any finding of Poor Professional Performance must result in the imposition of a sanction and, in the case of a sanction imposed under S. 71(a) of the Act of 2007, permits no appeal, it was appropriate to imply or import a requirement that a single lapse or offence must achieve a threshold requirement of being "serious".

Justice Kearns also had regard to the comments of Keane J. in ***O'Laoire .v. Medical Council*** as follows:

"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 this profession in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners."

In particular Justice Kearns, whilst noting the 2007 Act changed the requirements which could justify the imposition of a sanction, attached significance to the following statement of Justice Keane in ***O'Laoire v The Medical Council***:

"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."

It should be noted that in the subsequent Supreme Court appeal in *Corbally*, Justice Hardiman also had particular regard to the above quoted passage.

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

Justice Kearns in the High Court again approved the principles outlined by Jackson J. in *Calhaem's* case and was of the view that a single slip or error of a minor nature should not normally constitute poor or deficient professional practice. However, he was of the view that to exclude a grave error, albeit one occurring on a single occasion, would be to apply an interpretation which would undermine the purpose of the 2007 Act and in essence allow a 'one free strike' scenario which would be contrary to the interests of both the medical profession and the public generally. He also expressed the view that a non-causative lapse must be seen as less serious in character than the one which causes damage.

Justice Kearns indicated that the question to be considered by him in a judicial review context involved asking the question of whether the findings and sanction made against Professor Corbally were proportionate on the facts of the particular case.

In respect of allegation number 1, he was satisfied that the Fitness to Practise Committee, could and indeed was obliged, to make the finding of fact which it did, but was mistaken in characterising it as Poor Professional Performance given that the error of Professor Corbally was not a very serious one and made no real contribution to the eventual procedure carried out by Dr. Tareen. He was of the view that there was no evidence to warrant a finding that it contributed to the error or that the surgical team had any regard to it.

In relation to allegation number 6, he noted Professor Corbally delegated the procedure to a competent delegate and delegated the task by reference to the theatre list. There was evidence before the Fitness to Practise Committee that any person to whom Professor Corbally delegated the procedure would adhere to the hospital policy of conducting a surgical pause during the course of which the delegate would familiarise himself with the case notes prior to surgery. Given the circumstances of the communication (Professor Corbally was hurrying away to deal with an emergency), Justice Kearns did not consider that a finding of Poor Professional Performance could rationally be said to arise when the instruction given was so easily capable of being clarified by Dr. Tareen in advance of the specified procedure.

Justice Kearns stated that the findings at allegation 8 were repetitious and could not stand in view of the findings he had made in relation to allegations 1 and 6. Therefore the findings in relation to allegations 1, 6 and 8 were quashed by the High Court.

6. EFFECT OF THE HIGH COURT DECISION

While some aspects of the judgement of Justice Kearns were not entirely clear, the effect of the High Court decision appeared to be as follows:

a) A single act or omission could in principle amount to Poor Professional Performance.

b) In order for a single act or omission to amount to Poor Professional Performance, it must achieve a threshold requirement of being a "serious error". An alternative formula for this threshold requirement, but one which is similar in substance, was this single error a "grave" error?

c) There are passages in the *Corbally* judgment which suggested that the threshold requirement may have raised the bar even higher, and that a single act or omission must reach the higher standard of "very serious".

d) In assessing whether a single act or omission is sufficiently serious to constitute Poor Professional Performance, it is necessary to consider causation of damage as a relevant and indeed potentially determinative issue. According to Justice Kearns a non-causative single error must be seen as less serious in character than one which causes damage.

7. APPEAL TO THE SUPREME COURT

The Medical Council appealed the decision of the High Court to the Supreme Court and the central issue for determination on behalf of the Medical Council was essentially the extent to which once-off errors can be the subject of a finding of Poor Professional Performance within the meaning of the Medical Practitioners Act 2007.

For his part, Professor Corbally sought clarification as to the extent to which a once-off error in a handwritten description of a proposed surgical procedure, which was not serious in its nature or effect, which misled no-one and which had no consequences, could be the subject of a finding of Poor Professional Performance within the meaning of the Medical Practitioners Act 2007.

The Medical Council conceded that if it were necessary, in order to establish Poor Professional Performance, to prove behaviour on behalf of a doctor which *"seriously fell short of the standard expected"*, the Medical Council could not meet this test in the present case. However, its position was that the legislation did not require any threshold of *"seriousness"* to be met.

The Medical Council also put forward that there was no need, in order to make out a charge of Poor Professional Performance, to show that the facts established had been causative of any actual damage to a patient. While reserving the position that causation might be of some relevance on another set of facts, it contended that causation was of no relevance in the present case.

On this particular point it must be noted, however, that in the evidence notified to Professor Corbally before the public hearing, as substantiating the case against him, it was unambiguously stated that the erroneous mis-description of the operation did indeed have

consequences. The expert retained to give evidence against Professor Corbally on behalf of the Medical Council was a distinguished paediatric surgeon, Mr. Hugh W. Grant, who had wide experience both in South Africa and in the United Kingdom.

Mr. Grant, like most expert witnesses, had no personal knowledge of the factual components of the case and must accept the facts, which he requires to form an opinion on, from the instructions he receives from the solicitors on behalf of the Medical Council. In the present case, he made his report on the 20th November, 2011. The Supreme Court noted significantly that his report was headed:

"Report relating to incorrect surgery".

Mr. Grant also makes some very significant factual statements in his report:

"Professor Corbally started the chain of errors by the incorrect description of [the patient's] problem".

And:

"The incorrect description of the problem and operation led to the subsequent errors".

In his direct evidence given before the Fitness to Practise Committee, however, Mr. Grant did not allege that the incorrect description in the handwritten outpatient notes had caused the incorrect surgery.

It is thus apparent that the case the Medical Council first proposed to make against Mr. Corbally was that his mis-description of the operation did in fact have consequences. These consequences, the result of what Mr. Grant calls *"the subsequent errors"* included the patient being subjected to the incorrect surgery (the lingual frenulum rather than the upper labial frenulum).

At the hearing before the Medical Council, in cross-examination, Mr. Grant agreed that Professor Corbally had undoubtedly diagnosed the patient's problem as being located in the upper labial frenulum; that he had correctly described this in a contemporaneous letter to the patient's general practitioner and that he had correctly inputted this information into the admissions system.

Notwithstanding these matters, Mr. Grant held the view that the original mis-description *"in this case led to a chain of events"*. He did however concede that if the admission note had not been properly registered by the hospital system then "*the hospital process compounded the problem"*. When it was put to him that the sole factor which caused the incorrect surgery *"was the failure to accurately input the admission card"* he repeated that *"I think it compounded the error, yes"*. However, it is clear from the facts of the case that the outpatient notes mislead no-one because no-one read it prior to the first operation.

Mr. Grant had also formed the impression that the Senior House Officer, Dr. Orafi, who took the consent from the patient's mother, had read the original handwritten outpatient notes before the operation but it clearly emerged in evidence that this was not the case.

Dr. Orafi gave evidence before the Fitness to Practice Committee and she described her interaction with the mother of the child and said that she had the words *"tongue tie upper frenulum"* pointed out to her by the mother. She said that she wrote *"diagnosis – upper frenulum. Proposed surgery – tongue tie upper frenulum"*. She said she got that information from her discussion with the mother and from the admission card and the chart. She said

she understood precisely what was planned and she understood it as *"kind of a tongue tie release on the upper frenulum"*. She said she wrote on the consent form *"tongue tie upper frenulum and underlined the word upper"*. She said she did this because *"I know that the consent form is what is looked at in the operation theatre."*

Dr. Orafi said that she had first thought that she would be present at the operation but in fact was diverted elsewhere. In cross-examination she was asked whether she acknowledged *"that in retrospect you should have communicated this issue [the upper frenulum issue] up the line"*. She answered *"Definitely yes, definitely".*

Dr. Tareen, in his *"Incident Report"* attributed the performance by him of the incorrect operation to a lack of clarity in the consent form. However, Justice Hardiman noted that he saw no lack of clarity and that Dr. Orafi had actually underlined *"upper frenulum"*.

Justice Hardiman also noted that there was no evidence that the surgeon, the anaesthetist, or any other person in the theatre at the time of the first operation had read Professor Corbally's handwritten note before the operation.

Accordingly, Professor Corbally was originally pursued on the basis that the erroneous entry in the outpatient notes had caused the *"chain of events"* which led to the subsequent performance of the incorrect surgery. However, this was shown to be incorrect.

The evidence established that although the hospital operated a policy of a *"surgical pause"* that simply did not work in the present case. The immediate cause of this was the failure of the computerised admission system to register the full description of the operation inputted by Professor Corbally. However, this does not explain why the surgical team did not become aware of the Senior House Officer's unmistakable indication on the consent form that it was the upper labial frenulum which was to be divided, which followed the mother's insistence that this was so.

It also seems the Medical Council's expert Mr. Grant, was not given to understand that the hospital's computer system would not take notice of the words "*upper frenulum"* and it appears that this did not become apparent until the he was cross-examined at the Inquiry on behalf of Professor Corbally.

Accordingly, Hardiman J expressed the view that it was quite clear on the evidence that neither Professor Corbally nor anyone else in the case was in any way confused or misled by the error. This was demonstrated by the fact that in Professor Corbally's note to the general practitioner and in his admission note, the procedure was correctly described. Justice Hardiman also noted (as Mr. Grant in his evidence had agreed) that the error was an obvious one that any person, certainly any medical person, reading the note and being aware that there is, anatomically, no *"upper lingual frenulum"*, would be aware that a slight error had been made. In this regard Hardiman J was of the view that Professor Corbally had simply made *"a slip of the pen"*.

Separately, the Supreme Court noted that in the course of the reply on behalf of the Medical Council, it was conceded that it was improbable that the Fitness to Practise Committee had followed the legal assessor's advice on the question of whether there was a seriousness threshold to be met. In ***McManus v The Medical Council*** (High Court, unreported 14th August, 2013) it was held that the Fitness to Practise Committee is entitled, if it wishes, to disregard the advice of its own legal assessor but the Court noted:

"While it was accepted that the Committee was nonetheless free to reject the advice of the legal assessor, it was necessary for the first respondent [that is, the fitness to Practice Committee] to give clear and cogent reasons for doing so".

Justice Hardiman was of the view that the Fitness to Practise Committee had not followed the legal assessor's advice which, it appears from the transcript, was along the lines set out in the English case of ***Calhaem*** but that there was no statement by the Fitness to Practise Committee of *"clear and cogent reasons"* for departing from the advice of the assessor. Accordingly, the representatives of Professor Corbally never had an opportunity to comment on the basis on which the Committee was actually going to approach the question of whether Poor Professional Performance had been made out.

Justice Hardiman indicated that if this ground alone had been pleaded, it might be sufficient to quash the decision of the Fitness to Practise Committee. However, he was conscious that the Medical Council wished to have clarity on whether there was a seriousness threshold for Poor Professional Performance and therefore Justice Hardiman delivered the majority decision of the Supreme Court in which he addressed this particular issue.

8. SUPREME COURT DECISION

In his decision, Justice Hardiman stated that:

"I would apply a "seriousness" threshold to a finding of poor professional performance, as well as to professional misconduct…only conduct which represents a serious falling short of the expected standards of the profession could justify a finding by the professional colleagues of a doctor of poor professional performance on his part, having regard, in particular to the gravity of the mere ventilation of such an allegation and the potential gravity of the consequences of the upholding of such an allegation."

In reaching the above conclusion, Justice Hardiman also had regard to the fact that there is no distinction in the sanctions available for Poor Professional Performance and Professional Misconduct.

Justice Hardiman also had regard to the public nature of such Inquiries and was of the view that before a medical practitioner can be subjected to the "*extremely threatening ordeal of a public hearing*" before the Medical Council, either for Professional Misconduct or for Poor Professional Performance, there must be reason to believe that what can be proved against him is something of a serious nature.

Justice Hardiman also identified that *"There are, both in the 2007 Act, and elsewhere, various private non-accusatorial, non-adversarial, strategies available to ensure high professional standards"*. This may ultimately mean that there are a greater number of complaints which result in a Performance Assessment being carried out in respect of a medical practitioner rather than a full Inquiry being held.

It should be noted that in the Supreme Court, Justice McKechnie also delivered his own judgment in this matter and he agreed with Justice Hardiman that, in the same manner as the phrase Professional Misconduct is qualified, so too must the term Poor Professional Performance be read as if qualified with the word "serious".

Justice McKechnie also saw no justification in treating any differently conduct, by act or omission, committed on a single occasion only and that to wait for *"persistent or repeated"* substandard events to occur may lead to patients being unnecessarily compromised. However, he was particularly clear that circumstances and context will be vital in assessing

whether particular conduct amounts to Poor Professional Performance or Professional Misconduct.

Justice McKechnie also did not believe it was either necessary or desirable to try and further define the term "serious" but he did express the view that *"conduct which can truly be described as trivial, minor or which can be classified as de minimis will fall outside the meaning "*.

Finally, Justice McKechnie expressed the view that whilst detrimental consequences or causative effect are not essential for findings of Poor Professional Performance or Professional Misconduct to be made, when they are present they are factors to be considered.

9. EFFECT OF SUPREME COURT DECISION

The Supreme Court has now recognised that medical practitioners are not infallible and while there may be a number of matters which, though not serious, may legitimately aggrieve patients or their relatives, statutory regulators must be capable of saying that a complaint, although legitimate, will not proceed to the point of a Fitness to Practise Inquiry unless it involves a serious act or omission.

As a result of the Supreme Court decision, the distinction between Poor Professional Performance and Professional Misconduct is perhaps unclear. However, the effect in practice is that matters of a minor or trivial nature should not proceed past the Preliminary Proceedings Committee or investigation stage. Those complaints that do progress must not only relate to something of a serious nature but there must also be *"prima facie"* grounds to believe that the allegations can be proven against the registrant in question.

The statement of Justice Hardiman in relation to the "*extremely threatening ordeal of a public hearing*" has led some to suggest that the Supreme Court decision may bring an end to public Inquiries before the Fitness to Practise Committee. However, while there has been a fall-off in the referral of complaints to the Fitness to Practise Committee for public Inquiry, I believe it may be going too far to suggest that public Fitness to Practise Committee Inquiries are a thing of the past.