[2019 IEHC 686

THE HIGH COURT

[2016/151 S.P.]

BETWEEN

DAWAR SIDDIQI

APPELLANT

AND

MEDICAL COUNCIL OF IRELAND

RESPONDENT

JUDGMENT of Ms. Justice Creedon delivered on Friday the 31st of May, 2019:

Background

1. This matter came before the High Court by way of an application by the appellant for cancellation of the decision of the respondent ("the Medical Council") dated the 23rd March, 2016, to attach certain conditions to the appellant's ongoing registration following a finding of poor professional performance in respect of certain matters by the Fitness to Practise Committee of the Medical Council.

2. The case was heard over thirteen days between the 9th November, 2017, and the 22nd June, 2018, to facilitate the availability of expert evidence.

3. The appellant, Dawar Siddiqi, worked as a locum consultant radiologist at Bantry General Hospital from May to September, 2013. On the 5th December, 2014, J.A. McNamara, CEO of Cork University Hospital, expressed concern over the appellant's fitness to practice primarily in relation to his reporting on CT scans. Consequently, the respondent made a complaint to its Preliminary Proceedings Committee ("the PPC") which, following investigation, referred the complaint to its Fitness to Practise Committee ("the FPC") on the 30th July, 2015.

4. Following a five-day hearing which took place from the 25th November to the 1st December, 2015, the FPC concluded in its report on the 9th December, 2015, that Allegation 1 against the appellant was proven in relation to eleven of the twenty-two cases identified by Dr. Peter Ellis in his reports of the 1st July, 2015, and 8th October, 2015 (two of the cases were withdrawn on Day 3 of the hearing), and that the allegation as proven amounted to poor professional performance. Whilst the FPC noted that the circumstances that Dr. Siddiqi, the appellant, found himself in when he commenced work in Bantry General Hospital were far from satisfactory, they highlighted that he had been recruited on the basis of his competency and experience in CT on the basis of both his *curriculum vitae* and his interview when, on his (Dr. Siddiqi's) evidence, this was not the case.

5. Consequently, pursuant to s. 71(a) of the Medical Practitioner's Act 2007 ("the Act"), the Irish Medical Council, the respondent in this case, made a sanction decision at a sanction meeting on the 23rd March, 2016. They advised the appellant that they would be attaching certain conditions to his ongoing registration. The Medical Council attached seven conditions to the appellant's name remaining on the Register of Medical Practitioners following the finding of poor professional performance in respect of certain matters by the Fitness to Practise Committee of the Medical Council.

6. The following day (the 24th March, 2016), these conditions were communicated by letter to the appellant, Dr. Siddiqi, under the provisions of the Medical Practitioner's Act 2007. Dr. Siddiqi was advised in relation to his professional performance. To "advise" is one of the sanctions under s. 71(a) of the Medical Practitioner's Act 2007. However, that is not the subject of this appeal. It is the conditions that the Medical Council imposed in relation to the continuation of Dr. Siddiqi's name on the register maintained by the Council pursuant to s. 7(c) of the Medical Practitioner's Act, 2007, that are the subject of this appeal. They were outlined in the letter to the appellant Dr. Siddiqi as follows: -

"(1) You must work with a nominated person who is 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) CT reporting.

(2) You must work with a nominated person who is acceptable to the Medical Council to formulate a professional development plan to the Medical Council within three months of the date on which these conditions become effective.

(a) You must meet with your nominated person who is 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 your nominated person who is acceptable to the Medical Council, supplying reports to the Medical Council about your progress when requested.

(b) You must agree to your nominated person who is acceptable to the Medical Council supplying reports to the Medical Council about your progress when requested.

(c) You furnish at the Medical Council's request evidence of your compliance with the conditions attached to the retention of your name in the register and agree to any such visit or inspection and/or report deemed appropriate by the Medical Council to confirm such compliance.

(3) You must be responsible for and discharge any and all costs involved in the implementation and compliance with the above mentioned attached to the retention of your name in the register.

(4) That these conditions attached to the retention of your name on the register remain in place for a minimum period of two years."

7. While the Medical Council also advised the appellant, Dr. Siddiqi, in relation to his practise, it is accepted by the appellant that as far as this sanction is concerned, it cannot be part of the reliefs he seeks in these proceedings by reason of the provisions of the Medical Practitioner's Act, 2007, ss. 71(a), 74 and 75. This appeal, therefore, is confined to the conditions imposed pursuant to s. 71(c) of the Act.

Evidence

8. This case was heard over thirteen days between the 9th November, 2017, and the 22nd June, 2018. Evidence was given by the following witnesses;

9. Ms Orla Hannick Lennon, radiographer at Bantry Hospital, outlined to the Court that a radiologist is a medical doctor who is specialised in radiology for the purposes of interpreting images and diagnosing from those images. She said that 80% of her time is spent CT imaging and 20% time is spent plain film x- raying. She told the Court that she had been working in Bantry General Hospital since 2006. She said that in the Radiology Department there are two X - ray rooms and that one of these rooms doubles as a fluoroscopy room. She said that there was one ultrasound room and one CT scanner. In terms of staff, she told the Court that the allocation was 8.6 whole time equivalent staff however the actual number would always fluctuate up and down from this allocated figure . The staff was composed of one Radiology Services Manager who had overall responsibility for managing the unit, one Clinical Specialist Radiographer in CT scanning who takes overall responsibility for the CT. She said that at the time of this hearing this post was shared between herself and Aida Collins. There was also one Clinical Specialist Radiographer Post in ultrasound, one Senior Radiographer post and 3 basic grade posts.

10. She was referred to two documents while giving evidence. The first was a note of a meeting she had with Ms Jackie Daly. She said that she had phoned Ms Daly with concerns that she had about the CT service and how things were going within the X- ray department. She said that Dr. Siddiqi had asked her to sit with him and review CT scans on a number of occasions. She said in particular he would ask her to comment on CT pulmonary angiogram examinations and CT carotid angiograms. She said that she felt that despite what he said at the time, he had never done this as a means of furthering her own education as he would never pass comment on or critique any of her observations on what he was asking her to look at. He also never discussed with her any of his own findings on these images.

11. She said that subsequently, after reviewing some of his reports she had noticed that comments she had made to Dr Siddiqi were appearing “verbatim” on his reports and this had caused her concern as she was a radiographer not a radiologist. She said that as a radiographer she was not trained in either interpretation or diagnosis. She felt that Dr Siddiqi was doing this because he was unsure of himself. She reported this back to her RSM (Roisin O’Carroll) and told her she was not going to sit in on these sessions anymore and subsequently began to find excuses to avoid the sessions with Dr Siddiqi.

12. This witness was referred to a second memo which detailed the concerns that she had raised with Ms O’ Carroll, her RSM. This detailed her sitting in on sessions with Dr Siddiqi but also outlined that he had complained to her about his workload and how he wanted her to reduce his CT workload. She said that she had explained to him that she could not reduce the workload as the only numbers she had control over were outpatients. She informed him that the only way she could help was to try to reduce the numbers of outpatients attending each day.

13. She said further that she had to assist Dr Siddiqi in using the internet. She gave her opinion that using an internet search engine was new to him. She said the internet is something that in recent years, radiologists would commonly use when reviewing images. She said that most radiologists would now use radiology internet sites to assist them with findings and diagnosis. She said that when reviewing images for diagnosis Dr Siddiqi would use the hard copy versions as opposed to using digital monitors.

14. Under cross examination Ms Hannick Lennon outlined the difference between the PACS system (picture archive communication system) and the system that was in place in Bantry. She said that amongst her concerns was the fact that scans were being left unreported, sometimes by up to two weeks. She said that when the PACS system went live staff received training from Adam Davis, the PACS clinical specialist from CUH. She rejected the assertion put to her that when she was invited to sit with Dr Siddiqi her assistance was being sought with the technology and not with the diagnosis and she highlighted that during those meetings, it was only ever hard copies of scans that were reviewed therefore technical assistance was not needed. She said that she would also have discussed her concerns with her colleague Aida Collins. She was not in a position to point to particular cases or patients names where this happened.

15. Aida Collins gave evidence that she was also a radiologist at Bantry Hospital since 2006 with responsibility for the management of the CT department. She said that she too had raised concerns and was often asked by Dr Siddiqi to sit in on reporting sessions with him. She said that he would ask her for her opinion on the images and that she was concerned that what she expressed would form part of his final report. She said that when she communicated this concern to Dr Siddiqi he assured her the exercise was educational and something she would benefit from. She said she never got the impression her assistance was being asked for in order to use the technology and that Dr. Siddiqi's preference was to use hard copy images.

16. Dr Julie McCarthy gave evidence that she is a full time Cytopathologist in CUH and part-time National Clinical Lead with the Clinical Director Programme in Ireland. She also holds a PhD in cellular Immunology from Trinity College Dublin, she is a medical practitioner and a fellow of the Faculty of Pathology in Ireland. She outlined further that she is a Fellow of RCPI Ireland, holds a diploma in Cytopathology and a diploma in Quality and Leadership in Healthcare. She was the Clinical Director in diagnostics for CUH from Feb 2012 to December 2014. She confirmed to the Court that she had no direct dealings with Dr. Siddiqi. She said that the issue of radiology reporting came to her attention as part of her job profile. She said that she was contacted by Jackie Daly who was general manager of Bantry Hospital asking for guidance regarding concerns which Ms Daly had in respect of Dr. Siddiqi's work.

17. In August 2013 there was an executive board meeting and subsequent to this she was asked to arrange an audit of the appellant's work. In this regard there were a number of e-mails between her and Ms Daly which were opened to the court. These emails were to try to establish whether or not the complaints and the concerns that were raised were

valid. She explained that as a consultant cytopathologist she was not directly involved in the Radiology Department but as a part of her brief as Clinical Director she approached the Chair of the Division of Radiology in order to ascertain whether their department would facilitate and undertake an audit.

18. She said that during this time Ms Daly was becoming more cognisant that there were potential inaccuracies in reporting of radiology imaging. She confirmed that Dr Siddiqi was the only radiologist working on site in Bantry at the time. She said that ultimately the Faculty of Radiology commissioned an audit and that was externally conducted by two independent reviewers. The chair of the Faculty of Radiology reported back the findings of that audit to herself, Ms Jackie Daly and the Local Area Management Team. She named the two independent reviewers as being Professor Peter Kelly and Dr. Ugobi. She informed the Court that she did not have anything directly to do with selection process in relation to either the plain films, the ultrasounds or the scans that were used for the purposes of that audit.

19. Under cross examination, she confirmed that the Clinical Director is typically a consultant of senior years who takes a role within the HSE and whose job description is to ensure as much clinical excellence as is possible within the resourcing constraints in the HSE. She said that her brief included all forms of pathology radiology, endoscopy and outpatient cancer services at the time. She confirmed that her position was a local designation as distinct from a national designation and that she is now in a national role. She explained to the court how Bantry, Mallow and CUH hospitals form part of the South / Southwest Hospital Group. She confirmed that the audit eventually took place from August 2013 to September 2014

20. Ms Deirdre Doolan a clerical officer in the X-Ray department at Bantry General Hospital gave evidence about how the various films were selected for the audit. She confirmed to the court that she had no medical training. She said she selected random films with no set criteria. She was asked to compile a number of CT's plain films. She said there was a total of 640 that had to be audited - this was broken down into 62 CT, 44 ultrasounds and over 500 plain film. She explained how the reports were compiled, that they were dictated onto a tape and that she would have transcribed the reports onto the radiology information system. At that point the report would have been printed and brought to Dr Siddiqi to check and if he was satisfied he would sign off and verify the report.

21. Ms Roisin O'Carroll, a radiology services manager in Bantry General Hospital gave evidence. She outlined to the Court that she was the operational manager and line manager to the radiographers. Furthermore, she would have been in charge of the day to day running of the Radiology department. She explained to the Court that this was a small hospital and therefore the radiology department was also small scale. She said that the department was equipped with 2 plain X-ray rooms, it had one CT scanner and one ultrasound machine. She said that approximately 25,000 patients per annum would present at the department across the three modalities (i.e. general radiography, ultrasound and CT). With regard to management structure and personnel she told the

Court that she worked directly under the Hospital Manager as the Radiography Services Manager. She said that under that there are two Clinical specialist posts, one of which is in CT (this job was shared by two people) and the other in ultrasound (this job was also shared by two people). There was also a senior radiographer, a radiation safety officer, 3.6 basic rate radiographers and one consultant radiologist. She informed the court that Ms Jackie Daly was her immediate superior and that she herself was manager to Ms Orla Hannick and Aida Collins.

22. She said that as the department was small she would have worked closely with Dr Siddiqi on a daily basis as he was the sole radiologist. She said that she would have first met Dr Siddiqi on the 9th of May 2013. He discussed the backlog in films with her on their first encounter. She said that he raised with her that there were films from before his start date that had not yet been reported on. She agreed with him that this cohort of films would not be his responsibility and that they would be outsourced for reporting.

23. She said that most days that she was working with Dr Siddiqi he would seek her out and raise concerns. She told the Court that some of his concerns were not within the role of a radiologist. She said that for example, he raised HR issues such as wanting to manage the annual leave of the radiographers and the layout and design of the department. He also raised issues about his workload and the manner in which work was brought to him. She said that during this time and at his request, the office was renovated so that working conditions could be improved for him.

24. She said that his main concern was that he felt his workload was quite heavy. She said that she reported this to Jackie Daly and they explored ways to manage his plain film workload. She said she knew that he was struggling because of the delays in reports coming through. She said that he was not meeting his targets regarding turnover times of reports. She also stated that during Dr Siddiqi's five and a half months, they arranged to outsource approximately 34% of plain film reporting to be reported on by another hospital group.

25. She said that Dr Siddiqi requested that no CTs or Ultrasounds were to be conducted after 3pm so as to enable him to have time to complete his reports. Likewise, she said that also on foot of a request from Dr Siddiqi, a waiting list for outpatients was also introduced in order to reduce activity levels within the radiology department.

26. Whilst Ms O'Carroll did note that the department was a busy one for a sole radiologist she highlighted to the court that the same workload had been managed on a three-day week basis by the previous radiologist .Furthermore, once Dr Siddiqi indicated that he was struggling with the workload they worked with him to reduce it. She felt that following the outsourcing of certain scans and the introduction of a waiting list for outpatients attending the department his workload was reasonable for one radiologist.

27. She said that issues and concerns were brought to her attention regarding Dr. Siddiqi's performance. She said that clinical specialists had begun to indicate doubts about his confidence in CT reporting and that he was asking for their assistance. She named these

people as being Orla Hannick and Aida Collins. A document she wrote regarding concerns around Dr Siddiqi was opened to the court. This document noted that Ms Hannick had reported to Ms O'Carroll that Dr Siddiqi had often requested Ms Hannick to sit with him and asked her opinion while he was reporting. The rest of the document produced to her in court was a summary of concerns raised about Dr. Siddiqi at this time. The document outlined that when Aida Collins queried requests by Dr Siddiqi to sit with him she was told by him that it was a training exercise yet she believed she was learning nothing from these sessions.

28. She said that when she received this information she brought it to the attention of her superior Jackie Daly. Under cross examination she confirmed that Dr Siddiqi was contracted to a four-day week and that during that time as it was Summer, she herself would have taken 15 days off in annual leave. She confirmed that she was not present for any interactions between the clinical CT specialists and Dr. Siddiqi. She said that there was one specific case in relation to a brain tumour that she could remember where one of the clinical specialists Ms Aida Collins noted that she had disagreed with the radiologist. He had diagnosed an abscess and she had concerns that it was more serious than that. This is the only individual case she could recall.

29. She confirmed that until 4th September 2013, there was a manual dictation system in place for completing reports. These were then given to Ms Doolan to get typed up. They would subsequently be furnished to Dr Siddiqi for his approval and sign off. If he signed the report it would be circulated with the signature. If he wasn't happy he could insert changes which would go back to the clerical officer who would insert the changes and verify the report for circulation. There could be an addendum report but this would be an additional report. She outlined to the Court that the difficulties that Bantry Hospital had in getting the PAC system to go fully live meant that reports were still being dictated up until September of that year and therefore a voice recognition system was not in yet in place. She said that at the time, it was the electronic RIS system they were working with but continued with the old method of reporting from hard copy film.

30. Jackie Daly gave evidence that she was the Hospital Manager in Bantry from December 2010 to 10th Feb 2017. She said that she was responsible for the operational management of the hospital and she described to the Court the interviewing process that Dr. Siddiqi underwent prior to being offered his position in Bantry General Hospital. She said that she was not directly part of that process but a transcript of the interview by telephone was provided to the Court. She said that it was put to him that there was a lot of CT involved in the post as it was a standalone post in a small rural hospital. She said that he responded by saying that he had done a lot of CT in the past.

31. She said the Dr Siddiqi would have had support in relation to the PACS system. She said that after concerns had been raised to her by Ms Hannick and Ms O'Carroll she would have corresponded with other consultants and clinicians requesting feedback or commentary in relation to Dr Siddiqi.

32. Both radiographers indicated to her that some reports would vary between what was reported to them orally and what would be stated in the final report. She would have encouraged them to voice their concerns to Dr Siddiqi. She told the Court she raised the issues with her general manager as issues of this nature had never previously arisen in Bantry Hospital. She also said that prior to this there was never an audit conducted on the workload of the radiologist in Bantry. She provided statistics in respect of Dr Siddiqi's workload which were provided to Dr Ellis when he was asked to give his opinion on Dr Siddiqi's workload..

33. She outlined to the Court that the PAC system had to be introduced on a phased basis as the IT structure on site at the time was not adequate.

34. Expert evidence was given on behalf of the Medical Council of Ireland by Dr Peter Ellis, consultant radiologist, Royal Victoria Hospital, Belfast. Expert evidence on behalf of the appellant, Dr Dawar Siddiqi, was given by Dr Tanveer Butt, consultant radiologist and Head of Radiology Services, United Lincolnshire Hospitals, NHS Trust. Both experts gave evidence on foot of their written reports and both witnesses were extensively cross-examined on their evidence. The Court does not intend to traverse all of this evidence which is on the transcript. However, the Court will briefly refer to the 8 cases considered by Dr Peter Ellis, the expert on behalf of the Medical Council of Ireland to be serious. These cases were as follows: -

    (1) Case 6, where Dr. Siddiqi, the appellant, identified a primary 3cm lung tumour stating "*there is a 3cm mass within the bronchus intermedius*." Dr. Ellis opined that this scan was normal and that there was no mass in the bronchus intermedius as reported by Dr Siddiqi and further opined that to report the presence of a tumour where there is none is very serious. Dr Butt agreed in evidence that no 3cm lung tumour was present but indicated that Dr Siddiqi believed that the report dated the 29th August, 2013, was not his final correct report and may have related to a different patient. However, Dr Butt acknowledged that he had no knowledge of the existence or otherwise of another final report by Dr Siddiqi and that in the absence of another report he agreed that the discrepancy in respect of Dr Siddiqi's reporting of case 6 was a serious one. No evidence was advanced by the appellant with regard to the report not being the correct final report.

    (2) Case 8 involved a CT scan undertaken in order to identify whether a patient's prostate cancer had spread to secondary areas. Dr Ellis gave evidence of "a very large and very unsubtle par aortic lymphadenopathy" which was a significant spread of cancer that was not mentioned in Dr Siddiqi's report. Dr Ellis indicated that this omission was on the upper end of serious. Dr Butt referred to the appellant's assertions that he had written some further handwritten notes and orally advised the referring doctor of enlarged nymph nodes and further that an addendum report may have been lost. Dr Ellis gave his opinion of the inadequacy of any finding being given verbally to the referring doctor and confirmed that the omission was on the upper end of serious. Dr Butt accepted under cross-

examination that the discrepancy in Dr Siddiqi's report was on its face a serious error.

(3) Case 31 was a case where Dr Siddiqi was requested to carry out a CT scan of the lumber spine area of a patient with a possible disc problem in their back. Dr Siddiqi's report stated that disc material is centrally protruding out and bilaterally protruding on L3 and L4. Dr Ellis' report in evidence stated that the CT scan actually shows extreme lateral disc pressing on the right L3/4 nerve root and that this finding was missed by Dr Siddiqi. Dr Ellis' opined that given the patient's symptoms and the purpose for which a CT scan was request, it was clear that it was for Dr Siddiqi to report where there was any disc protrusion and that this was almost certainly the source of the patient's symptoms. Dr Butt stated that he would "really struggle with identifying the disc bulging observed by Dr Ellis", however he conceded that he could not disagree with the view expressed by Dr Ellis that this protrusion was the cause of the patient's symptoms. He did not agree with Dr Ellis' opinion that this was a serious matter.

(4) Case 34 involved a patient referred for a CT scan of the brain. Dr Siddiqi diagnosed a haemorrhage or, secondly, an abscess. However, Dr Ellis found that Dr Siddiqi's diagnosis was incorrect and that the CT scan showed "*an enhancing nodule within the oedema in keeping very much with the tumour".* Dr Ellis' report stated that "*this is clearly not*" a brain haemorrhage. In his evidence he stated that this was a clear tumour. Dr Ellis' finding was that this was a classical tumour which required urgent referral to a neurosurgeon. Dr Ellis described this as "*very basic radiology*" and indicated that "*of all of the cases in this case, this was the worst*". In his report, Dr Butt describes the description in Dr Siddiqi's report as "*absolutely right*" but in evidence conceded that he agreed with the analysis of the report provided by Dr Ellis, in particular, he agreed that the scan would require an immediate referral to a neurosurgeon and that such a referral would not have taken place based on the report provided by Dr Siddiqi. Insofar as Dr. Butt's report stated that there was no discrepancy in Dr Siddiqi's reporting of this case, in evidence, he confined that statement to the description of the scan rather than the diagnosis. Dr Butt further conceded that Dr Siddiqi's failure to mention the presence of a tumour amounted to a serious discrepancy.

(5) Case 39, this was a case in which Dr Siddiqi was asked to perform a CT scan of the chest, abdomen and pelvis for a patient with cancer of the oesophagus. Dr Ellis' report confirmed that it appeared that Dr Siddiqi had failed to measure the density value of what appeared to be cysts when performing the CT scan. While the steps to measure density were not taken by Dr Siddiqi, he nonetheless stated in his report that there were liver metastases. Dr Ellis stated that this was not apparent from the CT image itself and that Dr Siddiqi would need to have evidence of a high density value to support such a conclusion. Dr Ellis stated in evidence that Dr Siddiqi's reporting of these scans presented a serious issue and that the report if taken at face value, that the patient had an oesophageal cancer and liver

metastasis, would have taken the patient down a completely different treatment plan which could have included surgery. Dr Butt in his report stated that he did not think that" *mentioning about these hypo dense liver lesions to be compatible with liver metastasis in a known primary is overcall or wrong".* In evidence Dr Butt changed his position and conceded that Dr Siddiqi should not have called the lesions as cysts or metastasis and that he should have referred the case for further imaging. Dr Butt expressed the view that on the basis that Dr Siddiqi's overcall could have been confirmed or corrected at a later stage in the treatment process, he was of the view that the mistake was an overcall but not a discrepancy.

(6) Case 41, In this case Dr Siddiqi reported an unremarkable CT scan of the patient's thorax, abdomen and pelvis. Dr Ellis' report found that the CT scan displayed clear indications of symptoms that indicated cancer was present. Dr Ellis stated that Dr Siddiqi failed to mention bowel wall thickening which Dr Ellis very strongly suspected represented recurrent lymphoma. Dr Ellis stated that at the very least, the bowel wall thickening should be mentioned in his report which Dr Siddiqi had not done. Dr Butt said that it was hard to comment on the wall thickening because the images were in hardcopy and he did not have the previous CTs. He said that he would be very hesitant to mention the nonspecific findings of thickening of the small bowel as reoccurrence of lymphoma in the absence of other masses. Dr Ellis conceded that access to previous imaging would be useful but nevertheless maintained that Dr Siddiqi failed to mention this "subtle finding" in order to allow for further investigation to take place. In evidence, Dr Ellis stated that although his view and Dr Butt's report were "not far apart", in relation to the scan, the discrepancy in Dr Siddiqi's reporting was a serious one. In evidence, Dr Butt said that in light of the fact that Dr Siddiqi had been aware when looking at the scans of the patient's history of lymphoma, the discrepancy in his reporting was a serious one.

(7) Case 50, This patient was referred to Dr Siddiqi for a CT scan of the abdomen and pelvis. Dr Ellis stated in his report that though Dr Siddiqi correctly identified a mass in the oesophagus, he failed to mention the spread of the tumour in the "*left gastric coeliac and portal nodes*". Dr Ellis also identified liver lesions which "*could be metastases*" and which would require an MRI scan to clarify the situation. In his report, Dr Butt agreed that Dr Siddiqi failed to mention the upper abdominal lymph nodes *"which were important given the findings"* of a tumour in the oesophagus. He stated that Dr Siddiqi mentioned insignificant nodes in his report and said that *"inaccuracy in the measurement*" of the size of the nodes may be because there was no PACS system. He said he was "*not convinced*" about the liver lesions as they were "*too small to be characterised*" and "*appear simple cysts*". However, he accepted that they needed "*further assessment*" and "*should have been assessed with MRI liver or ultrasound liver*". Dr Ellis stated both in his report and in evidence that a further assessment would be unlikely to take place in circumstances where Dr Siddiqi had not flagged the abnormalities in the liver in the first instance. Dr Ellis gave evidence that the patient's lymph nodes "*were not remotely subtle*" and

"*massively enlarged*" and that the discrepancy was a serious one. In response to Dr Butt's view expressed in his report about the impact of the absence of PACS, Dr Ellis expressed the view that whether a doctor was looking at it on the PACS or on hard copy or on a viewing box or rollator, that the lymph node was not in any way normal on CT size criteria. Dr Butt's position changed during his evidence before the court, in particular he accepted that the lymph nodes were enlarged to an abnormal degree, that such a finding would be obvious whether a radiologist was using a PACS system or a hard copy, that it was a "*remarkably unsubtle*" finding and that it was a serious discrepancy on Dr Siddiqi's part.

(8) Case 59 was a case where a patient was referred to Dr Siddiqi for a CT of thorax. Dr. Siddiqi's report of this CT scan stated that there was a "*bronchiectasis and emphysema present*". In Dr Ellis' report, he stated that there was no evidence of bronchiectasis or emphysema at all. Dr Ellis stated that there was instead evidence of sarcoidosis, a lung disease, which was apparent from the presence of indicators such as calcified hilar nodes, interlobular septal thickening and perilymphtic nodules. In his report, Dr Butt accepted that Dr Siddiqi had not mentioned the basal atelectasis/fusion but stated that it is a "*small discrepancy*" and "*clinically insignificant*". He said that because he had mentioned the hiatus hernia and that "*could be the cause for the dilated oesophagus*". He did not agree that there is an "*overcalling*" of emphysema and bronchiectasis and thinks both of these conditions are present. Dr Ellis having considered Dr Butt's analysis concluded that his findings were "*so radically different to Dr. Butt's comments*" that he questioned whether Dr Butt was looking at the correct scan. He conceded that this is a difficult area of radiology and that not every radiologist is going to be aware of all those different pathways but that a radiologist should at least be able to know that that is not emphysema and is interstitial lung disease. Dr Butt in his evidence before the court resiled from the position outlined in his report in relation to the presence of emphysema, however, he stood by the remainder of the contents of the report and stated he disagreed with Dr Ellis' conclusion that this was a serious discrepancy. Dr Butt did, however, concede that this error when taken as part of a pattern of other discrepancies was a serious one.

35. In summary, as stated earlier, of the 19 cases at issue in these proceedings, Dr Ellis concluded that Dr Siddiqi's report in 8 of these cases, as outlined above, namely Cases 6, 8, 31, 34, 39, 41, 50 and 59 were each serious errors in their own right. Dr Ellis stated that Dr Siddiqi's reports in relation to the remaining eleven scans were each mild or moderate errors in their own right which when taken collectively and part of a pattern amounted to a serious error. In evidence, Dr Butt agreed that five of the cases, namely 6, 8, 34, 41 and 50 were each serious errors in their own right. He stated that a further eleven cases; 5, 9, 21, 22, 23, 26, 30, 36, 45, 59 and 62 were non serious discrepancies. Dr Butt said that in relation to six of these cases, cases 22, 26, 30, 36, 45 and 59, he conceded in evidence that these errors, although moderate in his view, amounted to a serious error when taken collectively as a pattern.

36. Dr Siddiqi, the appellant, gave evidence. He outlined to the Court that he is a registered medical practitioner who is trained in radiology. He said that he qualified in Pakistan, as a doctor in 1979 and he went through the various positions he held since qualification in various hospitals in the Middle East culminating in Sheikh Zaid Hospital as a specialist radiologist. He said that he gained a lot of experience in Sheikh Zaid Hospital and also gained experience when he came for short-term training to Hammersmith Hospital and then in the London Chest Hospital. He said that he never undertook MRI training.

37. He told the Court he had practised radiology for approximately 36 years and had never been made aware of any serious concerns in respect of his CT Reporting. He said that he then undertook fellowship training for radiology before doing a diploma with the Royal College of Radiologists. He said that once he finished that he came to Limerick as Registrar in Radiology in Limerick University Hospital. He said that as Sheikh Zaid Hospital was a federal postgraduate hospital while he was working there he would have provided training to junior doctors. He informed the Court that he had relevant examinations for specialising in radiology and that one of these was from Pakistan and the other was from the Royal College of Surgeons in the UK. He went on to tell the Court that he had worked in hospitals unsupervised as head of radiology and also had experience of cross-sectional radiology. He said that while he was working in a post as a locum consultant in Drogheda it was suggested to him he might want to apply for the post in Bantry. He said that he sent his CV to the agency interviewing for the job and they asked him to obtain references from Saudi Arabia. He confirmed that he only stayed 28 days in Drogheda as a locum consultant prior to taking up the position in Bantry.

38. When asked about his experience with the PACs system he told the Court that he had been using it since 2006 and that as far as he was aware this system was standard practice in most modern hospitals. He told the court it was used in Saudi Arabia and the better hospitals in Pakistan. He described it as being a better system as it did not require the radiologist to go through the administrative staff unless they wanted to query something. He explained to the Court how PACS works by explaining that when you report your X-Ray it starts writing straight away as the system has voice recognition. He said that while he is reporting he knows exactly what the PACS system is writing as it is being done as he speaks. He said the PACS system allows for corrections and reviews. He said that the information appears on a big screen as well as previous X-rays and information about examinations the patient has already undergone.

39. With regard to his interview for his position at Bantry he confirmed that his interview took place on the 18th April 2013. He said that this was via phone while he was still working in Drogheda. He said that he spoke to Marion Kearney in Administration. The record of the interview shows that a Doctor Kelly and a Doctor Oliver de Bhul were also part of the interview conversation. He said that at the conclusion of his interview he was unaware that PACS was not in place in Bantry at that time. He said that this only became apparent to him when he arrived on site and saw hard copy films in use. He said that he started working in Bantry on the 7th May 2013 and said that by his third day at work there he raised the issue of the backlog. He said that he told management that the backlog was

increasing and he said that they were still expecting him to deal with that as well as his current workload. He said that he became annoyed with management very early on in his time in Bantry.

40. He said that by the end of June 2013, staff were told that PACS was being introduced. He said that what ultimately happened was that the RIS system was introduced in July 2013 and PACS in September 2013. He said that having PACS would have made his work easier and he wold have been able to manage his time better had it been in place. His said that his workload was also impacted and increased by the ultra-sonographer having to unexpectedly take leave in July of that year. He said that in July 2013 Jackie Daly asked him how he felt about peer review and he said he would be open to this but he never got any further feedback either from her or the clinicians about it after they had this conversation. He said that when she mentioned this to him he asked her was there an issue with his work, that she said no and that it was just something that the hospital was introducing.

41. He said further that a Dictaphone was not provided to him meaning that he would often have to handwrite a note and then sent it to be typed. He also told the Court that viewing facilities provided to him for hardcopy film were not adequate and that any additional requests he made specific to this were denied. He conceded to the Court that he sought the help of the radiographers because they were quicker at using the computer to bring up images but that he was not relying on them for help with interpretation or diagnosis. He said that the help he was receiving from the radiographers in order to use the monitor allowed him to save time. He said he was not given any protected time to complete his reports and that resultantly, he often found himself working outside of his contracted hours. He said that he spoke with Deirdre Doolan about the process of reporting and signing off on reports and he raised the issue that unless a report was signed by him he could not be sure it was correct.

42. He went on to address specific cases. In respect of Case 8 he confirmed that it was his handwriting on the back of the clinical request card. He said this case related to a para aortic lymphadenopathy. He said that notes on the back of cards were taken as an aid memoir and the fact that the ultimate diagnosis/ report differed from what was on the back of his cards could be explained by the fact he was just taking these notes as an aid memoir for himself. Under cross examination he accepted this error as being a serious error.

43. With regard to Case 31 which related to a CT Lumbar Spine, he said that the referring doctor wanted to rule out any collapse of the vertebra. He said this CT was conducted because the patient was not able to lie flat for an MRI. Dr Siddiqi stated that nobody goes to surgery on a CT lumbar spine alone. Under cross examination he said it is only a radiologist's duty to recommend further investigations if they themselves cannot make a diagnosis. He said if the diagnosis had been established then it was his practice to leave further investigations up to the clinician.

44. He was questioned about his qualifications and conceded that the diploma he has, has been replaced by FRCR and that this could be misleading to any person reading his CV including a medical doctor. Discrepancies between his registration form and his CV were opened. It was put to him that on his CV from Global Medics it could be understood that he was a Consultant Radiologist as opposed to an Assistant Consultant Radiologist in King Fahad Medical Hospital. He maintained in his evidence that his DMRD allows him to be a consultant anywhere. Dr Siddiqi further accepted Dr Ellis' evidence in respect of PACS which was read out to him and further accepted that he had worked for a large part of his career using hard copy images and was well used to reading hard copy images. He further accepted that he was aware that he was being taken on for a single handed position in Bantry Hospital but he also accepted that he had not communicated this to his own expert Dr Butt. He accepted when it was put to him that his own expert Dr Butt on being shown the statistics opened in Court that it was his professional opinion that Dr Siddiqi's workload was heavy but not extremely heavy as previously opined by him in his report.

45. When it was put to him that there was no educational reason for Orla Hannick being with him for scans he maintained that she was only there for logistical help in bringing up the scans. He disputed Dr Ellis' view that he was not sufficiently trained to pick up on the findings or to assess clinical importance or to decide on the next steps in relation to CT scans. He disputed that he over called and under called particular scans. He confirmed that the monitor that was available to him in his rooms was more than a light box and that it could zoom in and out of scans but still stated that having Aida Collins or Orla Hannick help him use the larger computerised screen was a more efficient way at looking at the large volumes of scans he had to deal with.

The Arguments-Appellant's Submissions

46. Counsel for the appellant stated that the Medical Council placed no express restrictions on the practise of medicine by Dr Siddiqi as part of the conditions it imposed. They further stated that it was clear from the notice of inquiry dated 28th October, 2015, that the Council's Preliminary Proceedings Committee ("PPC") formed the opinion that there was a *prima facie* case warranting further action be taken in relation to a complaint made by J.A. McNamara, CEO of Cork University Hospital, following which the complaint was referred to the Council's Fitness to Practice Committee "on the grounds of professional misconduct and poor professional performance".

47. In the Notice of Inquiry the only allegations ultimately pursued were of poor professional performance, it being alleged that while practising as a locum consultant radiologist at Bantry General Hospital from May, 2013, to September, 2013, in respect of 62 CT scans reported on by Dr. Siddiqi and subsequently selected for review:-

(1) You made serious errors in one or more of the 22 cases identified by Dr. Ellis in his report dated on 1st July 2015; and/or

(2) Your rate of error arising from one of the above was unacceptably high."

48. The Appellant refers to the fact that the Medical Council commissioned a report from Dr Ellis, consultant radiologist, Royal Victoria Hospital, Belfast. His report reviews 62 CT scans and Dr Siddiqi's reports thereon. The appellant submitted that whereas Dr Ellis indicated that he had sight of the clinical request cards for each examination, it appeared that these were not in fact furnished to him until just prior to the hearing before the Fitness to Practise Committee. The Appellant further refers to the fact that in his report, Dr Ellis identified significant challenges in relation to the unsatisfactory nature of Dr Siddiqi's working conditions. He also outlined the limitations on the review he was tasked with carrying out.

49. The appellant submitted that of the 62 scans Dr Ellis was asked to review, he agreed with Dr Siddiqi's report on the scans in relation to 40 cases. They further state that Dr Ellis identified mild to moderate discrepancies between his opinion and Dr Siddiqi's reports in respect of a further 14 cases. He did not, however, consider these to be serious discrepancies and they were unlikely to have had any patient consequences. The appellant says that in the remaining 8 scans, he reported that he identified "*very serious discrepancies which could potentially have significant clinical consequences for the patients involved*". The appellant submitted that it was these latter 22 scans (14 + 8) which were the subject of the notice of inquiry despite Dr. Ellis not identifying serious discrepancies in the 14 scans in this group.

50. The appellant said that 62 scans were ostensibly selected as a random 10% sample of Dr. Siddiqi's CT scan reports for the purposes of an earlier audit carried out on behalf of the HSE by the Faculty of Radiologists of the Royal College of Surgeons in Ireland. However, the appellant says that analysis of the dates of the sample scans by reference to the reports actually completed over the relevant period does not disclose that it was truly random.

51. Dr Ellis furnished a second report to the Medical Council on the 8th October, 2015. The appellant said that Dr. Ellis revised his views in this report and criticised the appellant's clinical ability to interpret scans in 15 cases describing it as inadequate. In his conclusion, Dr. Ellis noted that the appellant, Dr Siddiqi "had demonstrated a pattern of failure to appreciate significant findings, misinterpretation of findings and lack of knowledge of what further investigations may be required for significant findings" and taken as a whole "this constitutes poor professional performance". Dr Ellis also identified significant contributory factors.

52. Counsel for the appellant said that following the hearing before the FPC on the 9th December, 2015, it decided that having regard to the evidence adduced, allegation 1 of the notice of inquiry was proven as to fact in 11 of the 22 cases referred to it and that this amounted to poor professional performance. Allegation 2 in the notice of inquiry was withdrawn by the Medical Council. The decision on sanction has already been referred to earlier in this judgment.

53. The appellant said that it is clear that the High Court may consider any evidence adduced or argument made to the FPC pursuant to s. 75(2) of the Medical Practitioner's Act, 2007.

54. The appellant argued that as the hearing in front of this Court is a de novo hearing, it is not a mere appeal of the combined decisions of the FPC and the Medical Council. In this regard, the appellants opened In *re M, a Doctor* [1984] IR 479, in support of this point.

55. Moreover, the appellant contends that had Dr Siddiqi decided not to appeal and the Medical Council had applied to the High Court to confirm its decision to impose conditions on his continued registration pursuant to s. 76 of the Medical Practitioner's Act, 2007, the powers of the court would have been relatively circumscribed and confined to the issues raised by the Medical Council's decision. The appellant opened *Medical Council v. Lohan-Mannion* [2017] IEHC 401, 23rd June 2017 (Kelly P.) in support of this assertion. They also argued that in the circumstances, requiring the appellant, Dr Siddiqi, to answer allegations that were found not proven by the FPC and not considered by the Medical Council when the question of sanction arose, imposes an additional and unfair burden in his appeal.

56. The appellant claimed that the onus of proof lies with the Medical Council to establish (1) the correctness of the finding that Dr Siddiqi has been guilty of poor professional performance and (2) the correctness of the Council's decision in relation to sanction and they opened again *In re M, a Doctor* [1984] IR 479, in support of this assertion.

57. The appellant further argued that the applicable standard of proof in this case is that of proof beyond a reasonable doubt. They opened *O'Laoire v. Medical Council* (unreported) Supreme Court, 25th July, 1997 (Hamilton C.J., O'Flaherty, Denham, Barrington and Murphy J.J.) and *Georgopolous v. Beaumont Hospital Board* [1998] 3 IR 132, in support of this assertion.

58. Furthermore, they argue that the only allegations facing the appellant, Dr Siddiqi, were poor professional performance as defined in s. 2 of the Medical Practitioner's Act 2007. They argue that it is accepted that the sanctions available to Medical Council under the 2007 Act in the case of finding "poor professional performance" are identical to those applying in the case of a finding of "poor professional conduct". Similarly, they accept that the High Court has cognate powers on any appeal by a registered medical practitioner against a sanction imposed for alleged poor professional performance.

59. The appellant opened the principles set out by the Supreme Court in *Corbally v. Medical Council* [2015] 2 IR 304, and stated that they are relevant to the matter at hand and set them out as follows: -

    (a) A threshold of "seriousness" must apply to findings of poor professional performance as well as to professional misconduct;

    (b) Only conduct that represents a serious falling short of the expected standards of the profession can justify a finding of poor professional performance;

    (c) Conduct that is sufficiently serious to merit public censure, admonishment or advice can constitute poor professional performance;

(d) The threshold of "seriousness" has to be met before a *prima facie* case for holding a public inquiry before the Medical Council is made out;

(e) A finding of poor professional performance does not depend on an assessment of a representative cross-section of practitioner's work, nor is such "fair sample" test a preliminary requirement to the making of a complaint against a practitioner;

(f) A finding of poor professional performance or misconduct does not depend on conduct that impairs practitioner's fitness to practice or which calls into question his or her registration, though such findings may have that effect;

(g) The same threshold of "seriousness" applies whether the allegation involves a single or multiple incidents or activity.

(h) Conduct that can truly be described as trivial, minor or that can be classified as *de minimis* would not meet the threshold of seriousness required.

60. Counsel for the appellant stated that the question arose as to whether or not Dr. Siddiqi, was guilty of poor professional performance in his reporting of CT images as alleged. Counsel for the appellant argued that Dr Siddiqi's reporting of 62 CT scans within the limitations and structural difficulties identified by Dr Ellis had been reviewed by up to four consultant radiologists; two radiologists (Prof. Peter McCarthy, consultant radiologist, Galway University Hospital, and Dr Sale Ogboni, consultant radiologist, Lagan Valley Hospital, Lisburn) (and perhaps a third arbitrator) on behalf of the Faculty of Radiologists of the Royal College of Surgeons in Ireland at the request of the HSE, and Dr Peter Ellis on behalf of the Medical Council. Dr Tanveer Butt, consultant radiologist and Head of Radiology Services, United Lincolnshire Hospitals, NHS Trust, has also reviewed the 22 scans whose reporting was impugned by Dr Ellis.

61. Counsel for the appellant opened a section of Dr Ellis' report for the Medical Council to further highlight the constraints under which Dr Siddiqi was working under. It stated: -

> *"Radiology involves decision making under conditions of uncertainty and, therefore, will not always produce infallible or perfect interpretations or reports. The issue of error in radiology has been known for many years and multiple studies have shown a discrepancy rate between observers of somewhere between 2 – 20%. Recent reviews have found "real time" error rate amongst radiologists in their day to day practise of approximately 3 – 5%. Errors are inevitable and the concept of necessary fallibility must be accepted. Also a threshold of competency is required of all professionals involved in the delivery of imaging services."*

62. They further highlighted that in his report, Dr Ellis cautioned against "hindsight bias". Moreover, they highlighted to the court that Dr Butt's reports noted that there is a range of reasonable reporting practises and that Dr Siddiqi did not fall out with them.

63. The lack of a radiology quality assurance process within Bantry General Hospital in accordance with the Faculty of Radiologists guidelines for the implementation of a national

quality assurance programme in radiology was also raised by counsel for the appellant as being a significant factor in this case. They argued that any issues would have been identified and appropriate action taken if there had been routine retrospective peer-review for evaluating diagnostic accuracy of radiology reports. They stated that the lack of appropriate clinical governance arrangements to effectively implement recommended guidelines, effectively left Dr Siddiqi isolated within Bantry Hospital. Given these circumstances, they argued that a finding of poor professional performance cannot be considered to meet the relevant evidentiary threshold and is inconsistent with the object of competence assurance programmes.

64. Furthermore, it was argued by the appellant that whilst Dr Ellis reported that he believed that there was poor performance in the present case, his report also recognised the fact that there were very significant mitigating factors such as: -

(i) Working alone.

(ii) A lack of governance arrangements within the hospital.

(iii) Poor IT support.

(iv) A heavy workload.

(v) Poor relationship with hospital management.

Dr Ellis also referred to high expectations and the non-availability of the PACS system and stated that while in his view, Dr Siddiqi's reading of the CT scans had demonstrated poor performance, they could be partly explained by the environment in which this doctor was placed. The appellant asserted that the above conditions constitute mitigating factors and that the court should be cognisant of these when determining what weight to attach to the evidence of experts when considering (a) whether or not Dr Siddiqi's work amounted to poor professional performance and (b) the appropriate sanction.

65. The appellant argued that the court has three options opened to it: -

(a) To conclude that Dr Siddiqi is not guilty of poor professional performance in which case no conditions apply.

(b) Accept the evidence of Dr Butt that any discrepancies in Dr Siddiqi's practise can be dealt with by him practising in centres with appropriate feedback mechanisms.

(c) Accept the evidence of Dr Ellis that the conditions imposed by the Medical Council were "frankly very reasonable".

The appellant further submitted that there is no evidence from any expert that would support any more onerous sanction being imposed.

The Arguments - Respondent's submissions

66. Counsel for the respondent submitted that the FPC's finding of poor professional performance was based upon "*the totality of the evidence, oral and documentary including exhibits and submissions".* They stated that whilst the FPC did take into account various mitigating factors, that it nonetheless found that the appellant had been recruited as a consultant with competency in CT and that he himself admitted in his own evidence that this was not the case. Despite the mitigating factors, the committee had stated that it was "*satisfied that this lack of competence by D. Siddiqi is a core element of his employment and was a significant contributing factor to the errors made by D. Siddiqi".*

67. The respondent opened the cases highlighted by Dr Ellis in his reports, where he identified 22 cases where the appellant's conduct constituted poor professional performance due to a low standard of competence in CT reporting. Two of these allegations (namely cases 42 and 54) were withdrawn on Day 3 of the hearing before the FOC and one further case was withdrawn during the course of these proceedings leaving 19 cases at issue in these proceedings.

68. In summary, the respondent stated that of those 19 cases, Dr Ellis concluded in his evidence that Dr Siddiqi's report in 8 of these cases (namely cases 6, 8, 31, 34, 41, 50 and 59) were each serious errors in their own right. Further that Dr Ellis stated that Dr Siddiqi's reports in relation to the remaining 11 scans were each mild or moderate errors in their own right which when taken collectively and as part of a pattern amounted to a serious error.

69. The respondent stated that in evidence, Dr Butt agreed that 5 of the cases (namely 6, 8, 34, 41 and 50) were each serious errors in their own right. Further that Dr Butt in evidence agreed that a further 11 cases (5, 9, 21, 22, 23, 26, 30, 36, 45, 59 and 62) were non-serious discrepancies. Of these 11 cases, in relation to 6 cases numbers 22, 26, 30, 36, 45 and 59, Dr Butt conceded in his evidence that these errors, although moderate in his view, amounted to a serious error when viewed collectively as a pattern.

70. The respondent noted that there was considerable agreement as regards the discrepancies in the scans as between Dr Ellis on behalf of the CEO and Dr. Butt on behalf of Dr Siddiqi. They stated that where there is disagreement, the respondents submitted that the court should prefer the evidence of Dr Ellis on the following grounds: -

    (i) He is the most trained, qualified and experience of the two experts.

    (ii) That it was clear from his evidence that prior to providing his report and before giving evidence, Dr Butt did not know the definition of "poor professional performance" on which he was purporting to opine and neither was he familiar with the Medical Practitioner's Act, 2007. "Poor professional performance", 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 practised by the practitioner.

(iii) And that in the course of his evidence under cross-examination before this Court, Dr Butt resiled from his professional opinions contained in his written reports.

71. The cases highlighted by Dr.Ellis were then categorised by the respondent as follows: -

(i) Serious discrepancies.

(ii) Mild or moderate discrepancies.

(iii) Mild or moderate discrepancies which when taken as a pattern amount to serious errors.

72. The respondent stated that Dr Ellis in his report states that radiology "*will not always produce infallible or perfect interpretations or reports*" and that errors are "*inevitable*". However, the respondents stated that Dr Ellis also stated that there is nonetheless "*a threshold of competency"* required of all professionals involved in the delivery of imaging services. The respondent said that Dr Butt agreed in evidence that there are certain mistakes or discrepancies which are so serious that they do not fall within the ordinary radiology discrepancy rate of between 3–5%. The respondent went on to say that reluctantly Dr Siddiqi agreed in cross-examination that the discrepancy rates (which he stated were between 3–5%) were not relevant where the error was serious.

73. The respondent pointed out that Dr. Ellis used hardcopies of the CT images and Dr. Siddiqi's reports in relation to those CT images as the sole sources in considering each case. They state that he was not aware of the clinical history or patient outcome and reached his own conclusions on each scan before looking at Dr Siddiqi's report. The respondent does confirm that Dr Ellis acknowledged that if he had been looking at the scans in a hospital environment, he would not have had the benefit of working uninterrupted.

74. Prior to the conclusions reached in the Faculty of Radiologists report, the respondents said that Dr Ellis prepared his report for the FPC from a review of the 62 CT scans conducted by Dr Siddiqi during the period that he worked in Bantry. They stated that the previous review had been conducted internally by the Faculty of Radiologists which assessed 10% of the appellant's scans. The respondent said that contrary to the appellant's assertion, it was Dr Ellis' evidence that he was aware of the existence of the audit by the faculty but that he did not view it before he did his report.

75. The respondent said that the appellant's legal submissions submit that the views of the appellant's expert Dr Butt, Dr Ellis and the authors of the faculty review "*cannot be considered ad idem in any major respect*". The respondent says that this suggests that a divergence of opinion exists as to whether the errors demonstrated in the 20 scans originally highlighted were of an acceptable nature which the respondent says is clearly not the case. They stated that first, it was hardly surprising that the appellant's expert's interpretation of the appellant's work contrasts with that of the respondent which is a matter for adjudication by this Court and that secondly, Dr Butt's assessment is limited to

20 cases as opposed to the 62 cases reviewed by Dr Ellis and the Faculty. The respondent further stated that insofar as the appellant appears to suggest that the differences in finding points towards a divergence in the clinical assessment, they respectively submit that this point is misconceived.

76. They stated that the Faculty report did not seek to assess whether Dr Siddiqi had demonstrated poor professional performance but instead addressed the issue of adverse impact. The respondent said that accordingly the conclusions of the Faculty are not comparable to the conclusions of Dr Ellis or Dr Butt but that nevertheless Dr Ellis' report aligns with the findings of the Faculty in relation to the discrepancies in each of the five cases identified by the Faculty.

77. The respondent further said that Dr Ellis reviewed the 62 scans which formed part of the audit by the Faculty. They state that Deirdre Doolan gave evidence that the 62 scans were selected as a random 10% sample of the appellant's CT scan reports. The respondent said that the appellant's submissions allege that an "*analysis of the dates of the sample scans by reference to the reports actually completed over the relevant period does not disclose that it was truly random*". The respondent said that nothing further is offered in support of this contention and the respondent respectively submits that there is no merit to this point advanced by the appellant.

78. The respondent further went on to address the appellant's working conditions and the appellant's contention that had there been routine retrospective peer review that "*any issues would have been identified early and addressed at discrepancy meetings"*. The respondent said that the appellant appears to suggest that in the absence of such meetings a finding of poor professional performance cannot be made. The respondent said that the review of the appellant's work conducted by the Faculty and by Dr Ellis both concluded that in relation to CT scanning, the appellant's knowledge was deficient. The respondent contended that the role of multidisciplinary meetings and peer review cannot supplant basic competency and the respondent claimed that it is clear from the report of Dr Ellis and from his evidence that the appellant requires supervision to meet basic competency in CT scanning.

79. The respondent asserted that whilst the appellant's working conditions may very well have contributed to the discrepancies, his deficiency remains in circumstances where the appellant applied for and purported to undertake a locum consultant position in a post that was unsupervised. The respondent further claimed that the appellant sought to rely on the failure of Bantry General Hospital to implement PACS (Picture Archiving and Communication System) during the course of the appellant's employment there particularly in circumstances where he had used PACS in his previous posts. The respondent stated that whereas there were difficulties in introducing PACS in Bantry General Hospital, the respondent's position is that the seriousness of the discrepancy in the appellant's reporting cannot be excused by the fact that the appellant was reporting using hardcopy scans and the respondent says that this position was endorsed by the evidence given by Dr Ellis. He stated: -

"I suppose before 2011 in the Republic of Ireland everybody was reading from hardcopies. So it is not really a basis for I don't think anybody has shown that since PACS came in that radiology reports have improved in quality dramatically. Yes, previous films are more available and yes, films that used to go missing on the ward are now available to you at all times. But other than that, you still apply your professional opinion to an image and I don't see why you should be much better with a PACS than you would be with plain film."

80. The respondent went on to say that the court should note that the appellant was aware when he commenced employment at Bantry General Hospital that the position was that of a single handed radiologist. The respondent claimed the clear implication of the expert evidence tendered in these proceedings is that the appellant lacked the requisite competence and experience to perform in that role. In that regard the respondent asserted that it should be noted that the appellant accepted that the CV he submitted for the position misrepresented the nature and seniority of the positions he had previously held.

81. Addressing the appellant's workload, the respondent noted that the appellant has suggested that the workload he was faced with in Bantry General Hospital was so large that it contributed to any errors made in his CT supporting. In that regard, the respondent made two points. Firstly, they stated that Dr Ellis was clear in his evidence that the appellant's workload was not particularly onerous and he supported that view with the statistics provided in respect of Dr Siddiqi's workload. And secondly, the workload was one which the appellant's predecessor was capable of managing on a three-day week basis in accordance with the evidence of Ms. Roisin O'Carroll. The respondent says that although it must be noted that the *Corbally* decision expressly states that workload is a factor in determining the seriousness of an error in cases such as this, the respondent submits that the appellant has advanced no credible evidence to ground any suggestion that the size of his workload was so great as to either excuse or mitigate the seriousness of his reporting errors.

82. Addressing alleged bias on the part of the respondent's witnesses, the respondent said, that in evidence, Dr Siddiqi alleged that Dr Ellis was not acting as an independent expert witness and was hired by the respondent to prove that Dr Siddiqi was not a competent radiologist. The respondent said that Dr Siddiqi also alleged that staff from Bantry General Hospital who gave evidence on behalf of the respondents were acting as part of a conspiracy against him. The respondents say that no evidence was offered in support of these propositions nor were they put to any other witness during the course of the proceedings.

The law

83. Section 71 of the Medical Practitioner's Act 2007, sets out the procedure to be followed by the Medical Council of Ireland in determining disciplinary complaints. Section 71 provides, *inter alia* that: -

"……. the Council shall, as soon as is practicable after receiving and considering the report of the Fitness to Practise Committee in relation to a complaint concerning a registered medical practitioner decide that one or more than one of the following sanctions be imposed on the practitioner:

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

Further s. 2 of the Medical Practitioner's Act 2007 sets out the definition of "poor professional performance" as follows: -

""poor professional performance", 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 practised by the practitioner."

In light of the Supreme Court's decision in *Corbally*, this definition must be read as if qualified by the word "serious".

Section 75 of the Act governs appeals and states: -

"Appeal to Court against Council's decision under s. 71.

(2) The Court may, on the hearing of an appeal under subsection (1) by a medical practitioner, consider any evidence adduced or argument made, whether or not adduced or made to the Fitness to Practise Committee.

(3) The Court may, on the hearing of an appeal under subsection (1) by a medical practitioner

(a) either

(i) confirm the decision the subject of the application, or
(ii) cancel that decision and replace it with such other decision as the Court considers appropriate, which may be a decision

(I) to impose a different sanction on the practitioner, or
(II) to impose no sanction on the practitioner,

and

(b) give the Council such directions as the Court considers appropriate and direct how the costs of the appeal are to be borne."

Further, the Medical Council of Ireland is empowered to publish advice to practitioners under s. 12 of the Medical Practitioner's Act 2007. The *Guide to Professional Conduct and*

Ethics for Registered Medical Practitioners (7th Ed.), published in 2009, was the applicable guide during the period between May and September, 2013. At para. 2.2, it defines poor professional performance as: -

> *"A failure by the practitioner to meet the standards of competence (whether in knowledge and skill or the application of knowledge and skill or both) that can reasonably be expected of medical practitioners practising medicine of the kind practised by the practitioner."*

84. The leading authority on the meaning of poor professional performance is the case of *Corbally v. Medical Council* [2015] 2 IR 304. In that decision, the Supreme Court concluded that there is a "seriousness" threshold that must be passed before a finding of "poor professional performance" can be made. It concluded that the definition of poor professional performance must be read as if qualified by the word "serious" in the same manner as the phrase "professional misconduct" is. The Court went on to state that "*it is neither desirable nor necessary to try by some other form of words or expression to further elaborate on what the word "serious" means. It can, however, be said that not every error, lapse or mishap will qualify: conduct which can truly be described as trivial, minor or which can be classified as de minimis will fall outside its meaning. Whilst outcome adverse consequence or causative effect are not essential where present such will be factors for consideration……"* The Court went on to indicate that while one incident can justify a finding of poor professional performance, it was acknowledged that it would be more difficult to meet the threshold of seriousness if there is but one incident alleged.

85. The summary of the main findings in the case of *Corbally* were set out in the appellant's submissions and are set out earlier in this judgment. O'Donnell J. in his concurring judgment emphasised that he did not believe that seriousness "*should mean very serious*" nor did he believe that "*only conduct sufficiently serious to put registration in issue is covered by the Act"*. O'Donnell J. concluded that conduct "*sufficiently serious to merit public censure, admonishment or advice, may constitute poor professional performance*." Importantly, he further stated at para. 58 that "*only a serious error or a series of errors (which may therefore be serious) can justify a finding of poor professional performance*."

86. The onus of proof lies with the Medical Council to establish (1) the correctness of the finding that Dr. Siddiqi has been guilty of poor professional performance, and (2) the correctness of the Council's decision in relation to sanction.

87. The applicable standard of proof in this case is that of proof beyond a reasonable doubt. This was contended for by the appellant who opened *O'Laoire v. Medical Council* (unreported) Supreme Court, 25th July, 1997 (Hamilton C.J., O'Flaherty, Denham, Barrington and Murphy J.J.) and *Georgopolous v. Beaumont Hospital Board [*1998] 3 IR 132, in support of this assertion and was not refuted by the respondent.

88. In *Hermann v. Medical Council* [2010] IEHC 414, Charleton J. stated that Court must decide what sanction is appropriate in light of the findings of fact which led to the imposition of the sanction by the Medical Council. He stated: -

"The Medical Council retains the burden of proving that the sanction was correct. The court 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."

Charleton J. went on to state the following test where the Court is considering an appeal under s. 75 as follows: -

"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. If 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."

89. Charleton J. went on to consider the range of sanctions available and the conditions in which each might apply in the case of *Hermann* as follows: -

"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."

90. Similar sanctions were considered in the case of *Medical Council v. Lohan-Mannion* [2017] IEHC 401. In that case, an anaesthetist admitted to professional misconduct in respect of absenting herself twice from theatre and failing to record the administration of certain drugs during surgery. She also admitted failings in monitoring a patient's blood pressure during surgery amounting to poor professional performance. The FPC recommendations for re-education and training in the management of anaesthesia in a theatre setting were confirmed by the Medical Council. Kelly P. stressed the leniency of the training and re-education sanctions within the range of available sanctions and stated as follows: -

"There is no doubt but that the sanction imposed here is at the lower end of the scale of sanctions that might have been applied. There is no element of suspension of the respondent from medical practice even during the time that she is satisfying the various conditions applied against her. Nonetheless, it is said that the Medical Council has adequately addressed its obligations and that its decision cannot be regarded as so unreasonable as to warrant the court refusing the application."

Decision

91. The Court has considered the evidence of all of the witnesses, in particular the two expert witnesses and the appellant himself who also gave evidence. The Court has also considered the case law opened by both the appellant and the respondent. Both experts gave extensive direct evidence and were also extensively cross-examined on their evidence. The Court does not intend to traverse the evidence of all of the witnesses or indeed the evidence of the two experts all of which is on the transcript but has outlined in this judgment details of the 8 cases considered to be serious by the respondent's expert.

92. The Court notes that the relevant legislation is the Medical Practitioners Act 2007 which sets out the procedure and defines poor professional performance. The Court notes that the leading authority on the meaning of poor professional performance is the case of *Corbally v Medical Council [2015]2 IR 304* which found that a "seriousness" threshold must be passed before a finding of "poor professional performance" can be made.

93. The Court accepts that the onus of proof lies with the Medical Council to establish (1) the correctness of the finding that Dr. Siddiqi has been guilty of poor professional performance and (2) the correctness of the Council's decision in relation to sanction. The Court accepts that the applicable standard of proof in this case is that of proof beyond a reasonable doubt.

94. There is a considerable amount of agreement between the two experts as set out above. The Court has been urged by the respondent, that where there is disagreement, to prefer the expert evidence of Dr. Peter Ellis for the reasons outlined by the respondent set out earlier in this judgment. In his evidence Dr. Butt confirmed that both at the time of finalising his report and when giving his direct evidence before this court he was not familiar with, nor had he been briefed on, the Medical Practitioner's Act, 2007, and in particular, the statutory definitions contained therein. He further confirmed that he was not familiar with the *Corbally* case and the impact of that decision on the statutory definition of poor professional performance on which he was giving his professional opinion to the Court. In respect of a number of cases; under cross-examination Dr. Butt resiled from the position he took in his report and made a number of concessions. The concessions made by Dr. Butt in respect of a number of the 8 cases considered serious by Dr Ellis are outlined earlier in this judgment.

95. In determining the facts of this case and in considering the expert evidence given by the experts before the Court, the Court notes that both experts are in agreement as to the seriousness of the five cases on which they agree. The Court further notes that the experts are in further agreement that six further cases, although mild or moderate errors in their own right, when taken collectively and as part of a pattern amounted to a serious error. As stated above, Dr. Ellis goes further in his evidence than Dr. Butt and indicates that eight of the cases could be considered serious for the purposes of the definition of poor professional performance as set down in the Medical Practitioner's Act, 2007, and that a further 11 cases, each of which were mild or moderate errors in their own right, when taken collectively and as part of a pattern amounted to a serious error.

96. In considering the expert evidence, the Court notes the factors submitted to it, set out above, as to why it should prefer the evidence of Dr. Ellis and having considered those factors and the evidence of Dr. Ellis and Dr. Butt, the Court preferred the expert evidence of Dr. Peter Ellis and where there is disagreement attaches more weight to his expert evidence.

97. In addressing the appellant's arguments in respect of mitigating factors the Court notes that whilst the FPC did take into account various mitigating factors, it nonetheless found that the appellant had been recruited as a consultant with competency in CT and that he himself admitted in his own evidence that this was not the case. Despite the mitigating factors, the committee had stated that it *was "satisfied that this lack of competence by Dr. Siddiqi is a core element of his employment and was a significant contributing factor to the errors made by Dr.*

98. The Court notes further that the respondent's expert Dr Ellis, did acknowledge a number of mitigating factors in forming his opinion of poor professional performance. Dr. Ellis in his report states that radiology "*will not always produce infallible or perfect interpretations or reports"* and that errors are "*inevitable*" but that there is nonetheless "*a threshold of competency*" required of all professionals involved in the delivery of imaging services. Dr. Butt agreed in evidence that there are certain mistakes or discrepancies which are so serious that they do not fall within the ordinary radiology discrepancy rate of between 3–5%. and Dr. Siddiqi agreed in cross-examination that the discrepancy rates (which he stated were between 3–5%) were not relevant where the error was serious.

99. With regard to the appellant's working conditions and the appellant's contention that had there been routine retrospective peer review that "…*any issues would have been identified early and addressed at discrepancy meetings"* the court does not agree that in the absence of such meetings a finding of poor professional performance cannot be made. The Court accepts the evidence arising from the review of the appellant's work conducted by the Faculty and by Dr. Ellis which concluded that in relation to CT scanning, the appellant's knowledge was deficient and further accepts the evidence of Dr. Ellis that the appellant requires supervision to meet basic competency in CT scanning. The Court is supported in this by the fact that the appellant applied for and purported to undertake a locum consultant position in a post that was unsupervised.

100. The appellant was aware that the position which he applied for at Bantry General Hospital was that of a single handed radiologist and he accepted in his evidence that the CV he submitted for that position misrepresented the nature and seniority of the positions that he had previously held. With regard to his workload the evidence from Dr Roisin O'Carroll was that this workload was managed by his predecessor on a three-day week basis and Dr Ellis opined on the statistics provided that the workload was not particularly onerous. Under cross examination Dr Butt agreed.

101. The appellant has sought to rely on the failure of Bantry General Hospital to implement PACS (Picture Archiving and Communication System) during the course of the appellant's employment there for errors in his work particularly in circumstances where he had used

PACS in his previous posts. The Court on the evidence does not accept that the seriousness of the discrepancy in the appellant's reporting can be excused by the fact that the appellant was reporting using hardcopy scans. The Court considers that the evidence suggests that the appellant was more comfortable with hard copy slides and Dr Ellis is clear in his evidence that there is no basis to suggest that radiology reports have improved dramatically in quality since the introduction of PACS and that he sees no reason why applying professional knowledge to a PACs rather than a plain film should impact the quality of the work.

102. There is no evidence before the Court to suggest any bias on behalf of any of the witnesses called on behalf of the respondent to include the expert witness.

103. With regard to the audit the evidence before the Court was that Dr Ellis reviewed the 62 scans which formed part of the audit by the Faculty and Deirdre Doolan gave evidence that the 62 scans were selected as a random 10% selection of the appellants CT scan reports. The Court finds no evidence as contended for by the appellant that the sample of scans was not a random sample. Furthermore the court notes that it was held in the case of *Corbally* that *"A finding of poor professional performance does not depend on an assessment of a representative cross-section of practitioner's work, nor is such a "fair sample" test a preliminary requirement to the making of a complaint against a practitioner;"*

104. The Court accepts the expert evidence of Dr. Ellis that of the 19 cases in issue in these proceedings, that Dr. Siddiqi's report in 8 of these cases, as outlined above, namely Cases 6, 8, 31, 34, 39, 41, 50 and 59 were each serious errors in their own right. The Court further accepts the expert evidence of Dr. Ellis that Dr. Siddiqi's reports in relation to the remaining eleven scans were each mild or moderate errors in their own right which, when taken collectively and part of a pattern amounted to a serious error.

105. Accordingly, the Court finds that the Medical Council has established beyond reasonable doubt the correctness of the finding that Dr. Siddiqi has been guilty of poor professional performance in accordance with the statutory requirements set down in the Medical Practitioner's Act 2007, as elaborated upon by the *Corbally* case.

106. The Court must therefore go on to consider the correctness of the Council's decision in relation to sanction. In that regard, the Court looks to the case of *Hermann v. Medical Council* [2010] IEHC 414 referred to above and the facts of this particular case, the range of sanctions that are available, and the evidence given by Dr Ellis at this hearing as to the reasonableness of the sanctions imposed. The Court finds that the sanctions imposed are reasonable and proportionate in all of the circumstances.

107. Accordingly, the Court does not accede to the application made by the appellant for cancellation of the decision of the respondent, Medical Council, dated the 23rd March, 2016, to attach certain conditions to his ongoing registration following their finding of poor professional performance.