Report of the Fitness to Practise Committee following an Inquiry held pursuant to Part 8 of the Medical Practitioners Act 2007

Registered Medical Practitioner:	Dr Andrea Hermann
Registration Number:	22741
Registered Address:	Galway.
Date of Inquiry:	6th Oct, 24th Nov, 25th Nov, 26th Nov, 7th Dec , 8th Dec, 9th Dec, 10th Dec , 14th Dec, 15th Dec, 16th Dec, 2009, 26th Jan, 27th Jan, 5th Feb, 8th Feb, 19th April, 2010
Members of Inquiry Committee:	Prof Anthony Cunningham Ms Catherine Early Ms Mary Buckley
Legal Assessor:	Mr Kevin Cross SC
Appearances -	
For the Chief Executive:	Mr. Eoin McCullough SC and Mr Patrick Leonard BL instructed by Ms Eimear Burke of Mc Dowell Purcell Solicitors.
For the Practitioner:	Ms Geri. Silke instructed by Mr Terence Moran of Hayes Solicitors.

The nature of the Complaint that resulted in the Inquiry:

The Committee noted that:

1. The Preliminary Proceedings Committee ("the PPC") formed the opinion that there was a prima facie case to warrant further action being taken in relation to the complaint of Mr Ron Bolger, Chairman, Galway Clinic, Doughiska, Co. Galway.

2. The PPC referred the complaint to the Fitness to Practise Committee on the grounds of professional misconduct and/or poor professional performance.

The Committee further noted that:

The allegations of professional misconduct and/or poor professional performance considered by the Committee were as follows:

That you, while employed as a Consultant Gynaecologist at the Galway Clinic:

1. In relation to the treatment afforded by you to your patient Patient 1 in or around January 2005:

    a) Failed to perform any or appropriate investigations before conducting the first laparoscopy and/or

b) Failed to provide the option to Patient 1 of conservative management for a small ovarian cyst and/or

c) Consequent on the first laparoscopy and arising from the symptoms exhibited by Patient 1 thereafter:

i) Failed to arrange for any or adequate investigations to be carried out and/or

ii) Failed to conduct any or adequate examination(s) of Patient 1 and/or

iii) Failed to make adequate records of the treatment afforded by you to Patient 1 and/or

iv) Failed to arrange for any or appropriate antibiotics to be administered to Patient 1 and/or

v) Failed to seek and/or secure the opinion of a surgical colleague(s) in respect of Patient 1's condition and/or

vi) Failed to appreciate the gravity of Patient 1's condition and/or

vii) Failed to carry out or arrange to be carried out appropriate surgical exploration on or before 27th January 2005 and/or

b) Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient 1 and/or

5. In relation to the treatment afforded by you to your patient Patient 5 in or around March 2008:

a) Failed to consider and/or offer to Patient 5 one or more alternative treatment strategies and/or

b) Failed to advise Patient 5 in relation to the heightened risk of post operative bleeding and/or

c) Carried out the surgical procedure when same was unnecessary and/or inappropriate and/or

d) Failed to take appropriate steps prior to undertaking surgery when you were aware or ought to have been aware of Patient 5's significant risk factors and/or

e) Took into account pressure exerted on you by Patient 5 when determining to proceed to surgery and/or

f) Failed to make adequate records of the treatment afforded by you to Patient 5 and/or

g) Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient 5 and/or

9. That you seriously fell short of the standards expected from a Consultant Gynaecologist in respect of the totality of the treatment afforded by you to the 7 patients referred to above.

Findings of the Committee:

Allegation 1a:

Failed to perform any or appropriate investigations before conducting the first laparoscopy

Having regard to the evidence adduced, the Committee found that :

Allegation 1a was not proven as to fact.

Reason:

Although Dr. Hermann may have admitted this allegation as being proved in conjunction with the global admission in relation to Patient [redacted] however the Committee was of the view that Dr. Hermann did in fact perform appropriate investigations before conducting the first laparoscopy.

The reasons for the Committee's finding can be found at the end of the findings in relation to Patient 1.

Allegation 1b:

Failed to provide the option to Ms[redacted] of conservative management for a small ovarian cyst

Having regard to the evidence adduced, the Committee found that :

Allegation 1b was proven as to fact.

Allegation 1b did not amount to professional misconduct.

Reason:

The Committee felt that there was not a serious falling short of the standard of competence expected among doctors.

The Committee finds that the test for professional misconduct was not established beyond reasonable doubt.

Allegation 1c:

Consequent on the first laparoscopy and arising from the symptoms exhibited by Ms[redacted] thereafter.

Allegation 1c(i) :

Failed to arrange for any or adequate investigations to be carried out.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(i) was proven as to fact.

Allegation 1c(i) did amount to professional misconduct.

Allegation 1c(ii) :

Failed to conduct any or adequate examination(s) of Patient 1.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(ii) was proven as to fact.

Allegation 1c(ii) did amount to professional misconduct.

Allegation 1c(iii) :

Failed to make adequate records of the treatment afforded by you to Patient 1.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(iii) was not proven as to fact.

Allegation 1c(iii) did not amount to professional misconduct.

Reason:

The Committee accepted the evidence of Dr. Maresh that the failure to make adequate records was not a serious falling short of the standards of conduct expected among doctors.

Allegation 1c(iv) :

Failed to arrange for any or appropriate antibiotics to be administered to Patient 1.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(iv) was proven as to fact.

Allegation 1c(iv) did amount to professional misconduct.

Allegation 1c(v) :

Failed to seek and/or secure the opinion of a surgical colleague(s) in respect of Patient 1's condition.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(v) was proven as to fact.

Allegation 1c(v) did amount to professional misconduct.

Allegation 1c(vi) :

Failed to appreciate the gravity of Patient 1's condition.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(vi) was proven as to fact.

Allegation 1c(vi) did amount to professional misconduct.

Allegation 1c(vii) :

Failed to carry out or arrange to be carried out appropriate surgical exploration on or before 27th January 2005.

Having regard to the evidence adduced, the Committee found that :

Allegation 1c(vii) was proven as to fact.

Allegation 1c(vii) did amount to professional misconduct.

Allegation 1d:

Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient 1.

Having regard to the evidence adduced, the Committee found that :

Allegation 1d was proven as to fact.

Allegation 1d did amount to professional misconduct.

Allegations 1 (b), c(ii), c(iii), c(iv), c(v), c(vi), c(vii) were all admitted by and on behalf of the practitioner and the Committee held the clinical diagnoses of PCOS was not confirmed by ultrasound and therefore the option of conservative treatment was not given, no adequate investigations were carried out, no adequate examinations were carried out, adequate records of treatment were not adopted, although the latter was not a serious falling short of the standards expected among doctors. Appropriate antibiotics were not administered at the appropriate time and Dr. Hermann failed to seek the opinion of surgical colleagues. It is hard to appreciate the gravity of a patient in [redacted]'s condition but Dr. Hermann failed to do so and Dr. Hermann clearly failed to carry out any appropriate surgical exploration before the 27th January, 2005 and failed accordingly to apply the appropriate standards of judgement in respect of the care afforded to the patient.

The Committee noted that in relation to the question of misconduct that this was admitted by Dr. Hermann and apart from allegation 1a which was not proved and allegation 1(b) and allegation 1c(iii) which do not amount to professional misconduct. Each of the other allegations as proved do amount to a serious falling short by Dr. Hermann of the standards expected among doctors. The Committee accepted the evidence of Dr. Maresh and Professor Bonnar.

Allegation 5a:

Failed to consider and/or offer to Patient 5 one or more alternative treatment strategies.

Having regard to the evidence adduced, the Committee found that :

Allegation 5a was not proven as to fact.

Reason:

The Committee was not satisfied beyond reasonable doubt that the allegations have been sustained.

Allegation 5b:

Failed to advise Patient 5 in relation to the heightened risk of post operative bleeding.

Having regard to the evidence adduced, the Committee found that :

Allegation 5b was not proven as to fact.

Reason:

The Committee was not satisfied beyond reasonable doubt that the allegations have been sustained.

Allegation 5c:

Carried out the surgical procedure when same was unnecessary and/or inappropriate.

Having regard to the evidence adduced, the Committee found that :

Allegation 5c was not proven as to fact.

Reason:

The Committee was not satisfied beyond reasonable doubt that the allegations have been sustained.

Allegation 5d:

Failed to take appropriate steps prior to undertaking surgery when you were aware or ought to have been aware of Patient 5's significant risk factors.

Having regard to the evidence adduced, the Committee found that :

Allegation 5d was proven as to fact.

Reason:

There was no patient specific plan in the case of this patient and in the knowledge that there were previous records in existence it was unwise for Dr. Hermann to have operated without having obtained the records.

Allegation 5d did not amount to professional misconduct.

Reason:

The Committee accepted the evidence of Dr. Maresh and that the conduct did not seriously fall short of the standards of care expected among doctors.

Allegation 5e:

Took into account pressure exerted on you by Patient 5 when determining to proceed to surgery.

Having regard to the evidence adduced, the Committee found that :

Allegation 5e was not proven as to fact.

Reason:

The Committee was not satisfied beyond reasonable doubt that the allegations have been sustained.

Allegation 5f:

Failed to make adequate records of the treatment afforded by you to Patient 5.

Having regard to the evidence adduced, the Committee found that :

Allegation 5f was not proven as to fact.

Reason:

The Committee was not satisfied beyond reasonable doubt that the allegations have been sustained.

Allegation 5g:

Failed to apply appropriate standards of clinical judgment in the care afforded by you to Patient 5.

Having regard to the evidence adduced, the Committee found that :

Allegation 5g was proven as to fact.

Reason:

The Committee accepted the evidence of Dr. Maresh that Dr. Hermann did not take all the necessary steps in relation to Patient[redacted]'s treatment.

Allegation 5g did not amount to professional misconduct.

Reason:

The Committee accepted the evidence of Dr. Maresh that this failure was not a serious falling short and the Committee was not satisfied beyond reasonable doubt that professional misconduct has been established.

Allegation 9:

That you seriously fell short of the standards expected from a Consultant Gynaecologist

in respect of the totality of the treatment afforded by you to the 8 patients referred to above.

Having regard to the evidence adduced, the Committee found that :

Allegation 9 was proven as to fact.

Reason:

The Committee noted the submission by Counsel on behalf of Dr. Hermann that in order to establish that allegation number 9 is proved that treatment in respect of each of the patients would have to fall short of the standards expected. The Committee did not accept same but took the view that over the totality of the patients that it reviewed and in particular in respect of patients 1, 2, and 8 that Dr. Hermann did seriously fall short of the standards expected from a consultant gynaecologist.

Allegation 9 did amount to professional misconduct.

Reason:

Given that the allegation itself refers to a serious falling short it follows that in the view of the Committee that professional misconduct has been established in respect of this allegation.

Other matters relating to the registered medical practitioner the subject of the complaint which the Committee considers appropriate to specify:

The hearings in respect of patients numbered 1 and 5 were in public. The hearings in relation to the other patients were in private. The Committee therefore holds that the judgment in relation to patients number 1 and 5 together with the recommendations in relation to sanctions (below) should be published. The recommendations in relation to sanction apply to each of the three patients (numbers 1, 2 and 8) in respect of which findings of professional misconduct and/or poor professional performances have been found. Therefore as professional misconduct has been found in relation to patient number 1 which was a public hearing the recommendations as to sanction (below) should also be published. The findings in relation to the other patients should be merely submitted to the Council for action. Having published the findings in relation to patients 1 and 5 as well as the recommendations as to sanction these of course should also be furnished in the usual way to the Medical Council for consideration.

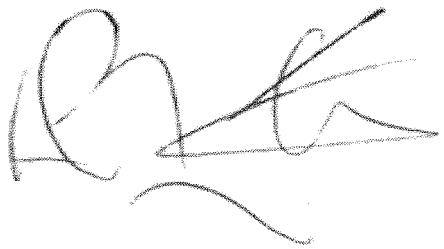
Recommendations to Council as to sanction:

The recommendations of the Committee as to sanction are in the context of the overall view that none of the actions of Dr. Hermann were wilful and must be taken in the context in which she was working including working as a sole gynaecologist without the option for peer review by colleagues.

The Committee also took into account aspects of the governance and procedures in the Galway Clinic which may have had an impact on Dr. Hermann's practice.

The committee therefore recommends as to sanction:

1. That Dr. Hermann be suspended for one year. Hopefully commencing as soon as is possible and during her year of suspension and in any event that she must work with a person nominated and acceptable to the Medical Council to formulate a Personal Professional Development plan specifically designed to address the deficiencies in the following areas of her practice;
   a. Her gynaecological surgical techniques
2. That Dr. Hermann meet with a nominated person acceptable to the Medical Council, on a regular basis to discuss her progress towards achieving the aims set out in her Professional Development Plan. The frequency of her meeting to be agreed by the nominated person and the Medical Council.
3. That Dr. Hermann agree to the nominated person acceptable to the Medical Council supplying reports to the Medical Council about her progress when requested.
4. That Dr. Hermann must provide evidence to the Medical Council of her ongoing and regular participation in relevant Continuing Medical Education and / or Continuing Professional Development.
5. On the completion of her period of suspension Dr. Hermann must confine her medical practice to working in hospitals in which there are at least three other gynaecologists who are on the Specialist Register
6. That Dr. Hermann be responsible for discharging all costs associated with the implementation of and compliance with these conditions
7. These conditions will remain in place for a minimum of three years.



_____ Chairperson

14th May, 2010.

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Date