



# Comhairle na nDochtúirí Leighis Medical Council

## Fitness to Practise Inquiry to be held in Public

<b>Scheduled date(s) for Inquiry</b>	4 <sup>th</sup> – 18 <sup>th</sup> and 26 <sup>th</sup> January 2016
<b>RMP subject of complaint</b>	Name: Dr Omar Hassan Khalafalla Muhamed Registration Number:402096 Address: Dublin 15
<b>Allegation</b>	Professional Misconduct and Poor Professional Performance
<b>Fitness to Practise Committee: (2 non-medical members + 1 medical member)</b>	Dr Michael Ryan (Chair), Medical Council, lay member Dr Abdul Bulbulia Fitness to Practise Panel, medical member Ms Meg Murphy Fitness to Practise Panel, lay member
<b>Legal Assessor</b>	Patricia Dillon , SC - Law Library, Dublin 7
<b>Appearance for CEO</b>	Frank Beatty instructed by McDowell Purcell Partnership,
<b>Appearance for RMP (if known)</b>	Not Represented
<b>Additional Information</b>	<ul style="list-style-type: none"><li>○ Relevant sections of the Medical Practitioners Act 2007 - Part 7/ Part 8/ Part 9: available at <a href="http://medicalcouncil.ie/What-we-do/Legislation/">http://medicalcouncil.ie/What-we-do/Legislation/</a></li><li>○ Guide to Professional Conduct and Ethics for Registered Medical Practitioner: available at <a href="http://medicalcouncil.ie/Media-Centre/Publications/2008-2009">http://medicalcouncil.ie/Media-Centre/Publications/2008-2009</a></li><li>○ Reporting on Fitness to Practise Committee Inquiries <a href="https://www.medicalcouncil.ie/News-and-Publications/Reporting-on-Inquiries/">https://www.medicalcouncil.ie/News-and-Publications/Reporting-on-Inquiries/</a></li><li>○ Leaflets available on the Medical Council website at: <a href="http://medicalcouncil.ie/Media-Centre/Publications/2010">http://medicalcouncil.ie/Media-Centre/Publications/2010</a><ol style="list-style-type: none"><li>1. 'What to do if called to give evidence - an information guide for witnesses'</li><li>2. 'Making a complaint about a doctor - a guide for patients'</li><li>3. 'What to do if a complaint is made about you - a guide for doctors'</li></ol></li></ul>
<b>Press contact(s)</b>	<i>Ms Lorna Farren</i> DD: 00353 +1 4983173/ Mbl: 087 9130288 / E: <a href="mailto:lfarren@mcirl.ie">lfarren@mcirl.ie</a>



Please scan the QR code for information about reporting on Fitness to Practise inquiries.

# Fitness to Practise Committee Inquiry to be held in Public

## List of Allegations

**Please note that the allegations below are as of the start of the Fitness to Practise Committee inquiry. Allegations can be withdrawn or amended over the course of an inquiry.**

**It is the responsibility of media reporting on an inquiry to ensure they record any withdrawals, amendments or changes to allegations over the course of an inquiry.**

### **ALLEGATIONS:-**

1. That you, while practising as a surgical Senior House Officer ("SHO") at the Midland Regional Hospital, Portlaoise (the "MRHP") failed to provide adequate or appropriate medical care to patients on the following occasions:
  - i. On or about the 17 September 2012, during a laparoscopic cholecystectomy, stood on the diathermy pedal when not in use, causing a burn injury to a patient; and/or,
  - ii. On or about 24 September 2012, unsuccessfully attempted to cannulate a patient, on a number of occasions, causing pain to the patient, in circumstances where cannulation was not necessary; and/or,
  - iii. On or about the 25 September 2012, failed to complete an adequate consent form in respect of a patient who was undergoing surgery for excision of skin tags at the peri-anal area; and/or,
2. That you, while practising as a surgical SHO at the MRHP failed to provide timely medical care to patients on the following occasions:
  - i. On or about 1 October 2012, while working in the day ward:
    - (a) failed to respond to a number of bleeps/pages from nursing staff; and/or,
    - (b) failed to admit patients and/or obtain patient consent to procedures on the day ward in a timely manner or at all; and/or,
  - ii. On or about the 5 October 2012, failed to respond to one or more bleeps/pages when your attendance was required in the day ward; and/or,
3. That you, while practising as a Surgical SHO at the MRHP displayed poor and/or inappropriate and/or aggressive behaviour when interacting with colleagues/patients on the following occasions:

- i. On or about 5 October 2012, attended the day ward, and spoke to members of staff, and in particular Ms [REDACTED] student nurse and Ms [REDACTED], staff nurse, in an aggressive manner; and/or,
  - ii. On or about 24 September 2012, spoke to the patient referred to at Allegation 1 (ii) in an inappropriate manner, while trying to obtain her consent to continue his attempts at cannulation; and/or,
4. That you, while practising as a surgical SHO in MRHP between on or about July 2012 to on or about December 2012, failed to adequately communicate with members of the nursing and/or medical team in respect of patient interactions; and/or,
5. That you, while practising as a surgical SHO at Mayo General Hospital ("MGH") failed to provide adequate or appropriate medical care to patients on the following occasions:
  - i. On or about 12 and or 13 December 2013, while practising as a surgical SHO at MGH, in circumstances where Dr [REDACTED] intern, required assistance in managing the care of a patient who was experiencing an upper gastrointestinal haemorrhage:
    - (a) failed to respond clinically in a manner that contributed to the assessment, resuscitation and/or welfare of the patient; and/or,
    - (b) left the ward without providing any support to the surgical intern and/or,
    - (c) failed to implement a plan with regard to the immediate management and/or welfare of the patient; and/or,
    - (d) failed to provide appropriate support to a junior member of the clinical team in circumstances where you were his more senior colleague; and/or,
6. That you, while practising as an Orthopaedic SHO at University Hospital Galway ("UHG") failed to provide timely medical care to patients on the following occasions:
  - i. On or about the 28 January 2014, when asked to review a patient, who had experienced an episode of weakness, by Ms [REDACTED]:
    - (a) were slow to react to assess the patient; and/or,
    - (b) failed to appreciate the seriousness of the patient's condition; and/or,
    - (c) failed to make a timely referral to the relevant medical specialist; and/or,

- ii. On or about the 3 February 2014, in the context of being requested by Ms [REDACTED], staff nurse, to attend to a patient who had presented with a bi-lateral calcaneum, and was experiencing significant pain, failed to attend to review the patient in a timely manner or at all; and/or,
  - iii. On or about 30 January 2013, when working with Mr [REDACTED], Orthopaedic Registrar challenged and/or refused to follow Mr [REDACTED] instruction to you to contact the on-call medical team to review a patient who had presented with a patellar fracture, in a timely manner or at all; and/or,
  - iv. Between on or about 2 February 2014 to on or about 3 February 2014, failed to prioritise a 3 year old child's admission in circumstances where he had presented with a fractured humerus and was awaiting orthopaedic review, in a timely manner or at all; and/or,
  - v. On or about the 2 February 2014 to on or about 3 February 2014, in the context of attending to a patient who had been diagnosed with acute pancreatitis with elevated Amylase levels (700), failed to order a CT scan for the patient in the manner requested by Mr [REDACTED], Senior Orthopaedic Registrar and Spine Fellow, in a timely manner or at all; and/or,
  - vi. On or about the 2 February 2014 to on or about 3 February 2014, in the context of attending to patient who presented with a peri prosthetic fracture of the femur:
    - (a) took an excessively long time to obtain the patient's history and/or,
    - (b) failed to recognise how unwell the patient was; and/or,
    - (c) failed to assess the patient for analgesia in a timely manner or at all; and/or,
  - vii. On or about the 2 February 2014 to on or about 4 February 2014, in the context of attending to a patient who had undergone a hip-hemiarthroplasty, failed to document a telephone interaction with the consultant microbiologist, during which it was recommended that there should be a change to the patient's antibiotic regimen, in timely manner or at all; and/or,
7. That you, while practising as an orthopaedic SHO at UHG failed to provide adequate or appropriate medical care to patients on the following occasions:

- ii. On or about the 2 February 2014 to on or about 3 February 2014, in the context of attending to a patient who had undergone a hip- hemiarthroplasty:
    - (a) failed to properly assess the patient post operatively; and/or,
    - (b) did not properly describe the patient's condition in the patient's notes; and/or,
    - (c) failed to recognise how unwell the patient was; and/or,
  
  - iii. On or about the 13 January 2014 to on or about the 3 February 2014, in the context of affording care to an elderly patient who had presented with a neck of femur fracture, failed to demonstrate an adequate or any knowledge of proper prescribing practices in that you:
    - (a) prescribed a two week dose of OxyContin and Oxynorm to the patient in circumstances where this medication was not clinically warranted; and/or,
    - (b) failed to review the patient's drug chart in order to consider the patient's medications while she was a patient in UHG; and/or,
    - (c) failed to demonstrate an understanding of the level of pain that the patient was experiencing; and/or,
    - (d) failed to demonstrate a level of clinical knowledge expected of an SHO in that you were unable to explain the difference between OxyContin and Oxynorm when asked by a colleague; and/or,
  
  - iv. On or about the 13 January 2014 to on or about the 3 February 2014, in the context of attending to a patient, who was diagnosed with pulmonary oedema, failed to provide adequate care in that you:
    - (a) failed to intervene when the patient's condition deteriorated; and/or,
    - (b) failed to take charge of the patient's care; and/or,
    - (c) allowed an intern and nursing staff to take charge of the treatment of the patient; and/or,
8. That you, while practising as an orthopaedic SHO at the UHG demonstrated a lack of clinical knowledge and/or poor insight on the following occasions:

- i. On or about 1 February 2014, in the context of treating a patient who presented for a semi-elective tumour biopsy and had a low grade temperature on admission, failed to demonstrate the level of knowledge expected of an orthopaedic SHO, in that you were not familiar with the appropriate blood tests to be carried out on the patient when asked by Dr [REDACTED] consultant orthopaedic surgeon; and/or,
- ii. Failed to demonstrate basic knowledge of protocols in relation to *inter alia*: antibiotic thromboprophylaxis and treatment, deep venous thrombosis prophylaxis and analgesia; and/or,
- iii. On or about the 2 February 2014, failed to demonstrate a level of knowledge expected of an SHO in that you failed to observe the aseptic technique when handling blood samples and subsequently handling telephones without changing gloves; and/or,
- iv. On or about the 2 February 2014 to on or about 3 February 2014, failed to demonstrate an acceptable level of knowledge of infection control and/or appropriate aseptic practices for theatre in that you:
  - (a) after scrubbing your hands in preparation for theatre, proceeded to re-contaminate them by touching a non-sterile area; and/or,
  - (b) failed to wear theatre shoes or overshoe covers when entering an aseptic area; and/or,
- v. On or about the 2 February 2014 to on or about 3 February 2014, in the context of affording care to a 3 year old child who had presented with a fractured humerus, failed to display an adequate and/or any knowledge regarding the significance of non-accidental injury in children; and/or,
- vi. On or around 3 February 2014, while attending a trauma conference, failed to demonstrate an acceptable level of clinical knowledge in that you:
  - (a) failed to demonstrate an understanding of the implications for treatment for an intracapsular versus extracapsular fracture of the femur; and/or,
  - (b) failed to understand the implications of possible renal failure on the elderly when prescribing analgesia; and/or,

- vii. On or about the 17 February 2014, during a trauma meeting/teaching session, misidentified an x-ray image of an ankle as being one of an elbow; and/or,
9. That you, while practising as an Orthopaedic SHO at UHG demonstrated bizarre behaviour and/or did not as a member of a team on the following occasions:
- i. On or about 13 January 2014 to on or about 3 February 2014 wore inappropriate head gear during a spine operation that was unnecessary more appropriately suited to wearing during a hip operation and/or did not make prior enquires with members of staff regarding whether or not the head gear was required for the surgical procedure; and/or,
  - ii. On or about 13 January 2014 to on or about 3 February 2014 when requested to carry out actions by other members of the hospital team questioned instructions and/or directions given; and/or,
  - iii. On or about the 13 January 2014 to on or about the 03 February 2014, failed to act as a member of the orthopaedic team; and/or,
10. That you, while practising as an orthopaedic SHO at the UHG displayed poor communication skills on the following occasions
- i. On or about the 13 January 2014 to and/or about the 03 February 2014, failed to adequately communicate with members of the nursing and/or medical team in respect of patient interactions; and/or,
11. That you, while practising as an orthopaedic SHO at the UHG displayed poor and/or inappropriate and/or aggressive behaviour and interaction with colleagues/patients on the following occasions:
- i. On or about the 13 January 2014 to and/or about the 3 February 2014, behaved in a defensive and/or confrontational and/or intimidating manner towards members of the Hospital staff; and/or,

Such further allegations as may be notified to you in advance of the Inquiry

**Note that witness names are redacted in this notice, in the event that a witness may give evidence in private.**

# Glossary

**Admonish** - to reprimand (criticise) firmly.

**Allegation** - the charge or charges faced by the doctor because of the complaint.

**Adjournment** - a break in the inquiry before it has completed its deliberations. The inquiry will adjourn for lunch, comfort breaks and at the end of each day, if it lasts for more than a day. An adjournment may also be agreed to get additional evidence or if the inquiry has overrun.

**Censure** - to criticise strongly

**Chairperson** - the person who manages the Fitness to Practise Committee. The chairperson is also a member of the Fitness to Practise Committee and makes sure that the inquiry is conducted fairly.

**Cross-examination** - being questioned by barristers, solicitors or the Fitness to Practise Committee when giving evidence.

**Evidence** - what a witness says at the inquiry and documents or other records, including photographs, that are brought before an inquiry.

**Expert witness** - a witness able to give opinions on any matter falling within his or her area of expertise.

**Inquiry** - a hearing similar to a hearing before a court or tribunal.

**Legal Assessor** - a Senior Counsel (barrister) who advises the Fitness to Practise Committee.

**Fitness to Practise Committee** - a small group made up of at least one medical and two non-medical people.

**Poor professional performance** - a failure by the doctor to meet the standards of competence (whether in knowledge and skill, the application of knowledge and skill or both) that can reasonably be expected of doctors practising the kind of medicine that is practised by the doctor.

**Professional misconduct** –

Professional misconduct is:-

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

**Relevant medical disability** - a physical or mental disability of the doctor (including addiction to alcohol or drugs) that may impair the doctor's ability to practise medicine or a particular aspect of medicine.

**Sanction** - the type of penalty that the Medical Council can put on a doctor.