FITNESS TO PRACTISE PANEL OF THE
MEDICAL PRACTITIONERS TRIBUNAL SERVICE
2 TO 11 APRIL 2013
7th Floor, St James's Buildings, 79 Oxford Street, Manchester, M1 6FQ

Name of Respondent Doctor:	Dr Adam NOWAK
Registered Qualifications:	Lekarz 1984, Slaska Akademia Medyczna, Katowice
Area of Registered Address:	Belfast
Reference Number:	6117503
Type of Case:	New case of impairment by reason of: misconduct
Panel Members:	Mr J Donnelly, Chairman (Lay) Mr G Brady (Lay) Dr J Nicholls (Medical)
Legal Assessor:	Mr M Jackson
Secretary to the Panel:	Mrs S Montgomery Ms M Bonabana (5 April 2013)

Representation:
GMC: Mr Matthew McDonagh, Counsel, instructed by GMC Legal.

Doctor: Not present or represented

ALLEGATION

"That being registered under the Medical Act 1983, as amended:

1. In the period 1 June 2010 to 19 November 2010 you were employed by the Northern Health and Social Care Trust as a Locum Consultant Anaesthetist and were based at Antrim Hospital; **Found Proved**

First Incident 31 August 2010

2. You failed to provide good clinical care to Patient A in that at the time of her spinal anaesthetic procedure you

a. absented yourself from the delivery suite, **Found Proved**

b. did not inform staff of your location when absent, **Found Proved**

c. were not immediately contactable by staff

i. in case of a complication arising, **Found Not Proved**

ii. when a complication did arise; **Found Not Proved**

d. did not return to the delivery suite until after the patient was stabilised. **Found Proved**

3. Following your treatment of Patient A you acted inappropriately towards Dr G by;

a. grabbing his arm, **Found Proved**

b. attempting to drag him into a delivery suite, **Found Not Proved**

c. saying words to the effect of, "What have you said to the Sister" and "Let's go back and speak to her." **Found Proved**

Second Incident 15 October 2010

4. You failed to provide good clinical care to Patient B in that you:

a. did not make and/or record an adequate pre-operative assessment of Patient B, **Found Proved**

b. administered to Patient B both Parecoxib and Voltarol ("the drugs") at approximately the same time, **Found Proved**

c. did not possess adequate knowledge of the pharmacology of the drugs, **Found Proved**

d. failed to respond adequately to the concerns of a nursing colleague, **Found Proved**

e. prescribed Patient B paracetamol at a level exceeding that which is recommended, **Found Proved**

Third incident 20 October 2010

5. You failed to provide good clinical care to Patient C in that you

a. did not make and/or record an adequate pre-operative assessment of Patient C, **Found Proved**

b. did not recognise and/or adequately act upon the deterioration in Patient C, **Found Proved**

c. did not recognise the onset of anaphylaxis and/or adequately manage Patient C's condition, **Found Proved**

d. did not call for assistance, **Found Proved**

e. attempted to dismiss the help of anaesthetic colleagues **Found Proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. **Found Proved**

Determination on Service and Proceed

"Mr McDonagh: Dr Nowak is neither present nor represented at this hearing. The Panel has considered your submission that notification of this hearing has been properly served upon Dr Nowak.

You informed the Panel that the notice of this hearing, dated 1 March 2013, was sent by Royal Mail, Special Delivery Service, to Dr Nowak's registered address on 1 March 2013. The "tracking" document provided by Royal Mail, which is used to record the delivery of the package, indicates that the package was delivered on 5 March 2013 and was signed for. You submitted that on 1 March 2013 the Notice of Hearing was also sent to an effective e-mail address provided by Dr Nowak.

The Panel is therefore satisfied that the General Medical Council (GMC) has produced evidence which demonstrates that notification of today's proceedings has been properly served upon Dr Nowak in accordance with Rules 40(1) and (4)(b), and paragraph 8(2)(b) of Schedule 4 of the Medical Act 1983 (as amended).

You invited the Panel to proceed in the absence of Dr Nowak pursuant to Rule 31.

You informed the Panel that Dr Nowak has engaged with the case management procedure and has participated in most of the telephone conferences with the Medical Practitioners Tribunal Service (MPTS) and the GMC. You submitted that Dr Nowak has been aware of this hearing date since the Stage 1 Telephone Conference on 12 October 2012. At that conference Dr Nowak enquired as to whether he needed to attend for the duration of the hearing. He was advised that he was not required to do so but to give the matter careful consideration. Dr Nowak has taken part in subsequent telephone conferences and has participated in the discussion of case management decisions. You drew the Panel's attention to the minutes of the last pre-hearing case management telephone conference which took place on 5 March 2013 between Dr Nowak, GMC Legal and the Adjudication Listings Section of the MPTS. During the telephone conference Dr Nowak confirmed that he may attend the hearing for one day only. He was asked to put his intentions in writing but has not done so.

You also drew the Panel's attention to the numerous e-mail sent by GMC Legal to Dr Nowak and the telephone notes demonstrating the extensive efforts the GMC has made to contact Dr Nowak recently. It also notes that on 26 March 2013 Dr Nowak replied by e-mail indicating that he was going to forward his statement the following day. No such statement has been received and this appears to be the only e-mail recently sent by Dr Nowak to the GMC. You informed the Panel that the GMC Solicitor has attempted to contact Dr Nowak this morning by e-mail and telephone. In the telephone note, dated 2 April 2013, it is recorded that on contacting Dr Nowak's home number a male answered. When the GMC Solicitor asked to speak to Dr Nowak, the phone was passed to a female who identified herself as his wife who coincidentally is also Dr Nowak. She asked whether the caller wished to speak to her husband. The female advised that she would pass on a message to her husband that the GMC had called, but that she was unable to give any information regarding attendance at this hearing.

You drew the Panel's attention to paragraph 18 of the judgment of Rose L.J. in *R v Jones* [2002] 2Cr. App. R.9, and submitted that relevant parts of this paragraph should be taken into account in considering whether to proceed in Dr Nowak's absence.

The Panel accepted the Legal Assessor's advice who endorsed the approach set out in *R v Jones* [2002] 2Cr. App. R.9 and also referred to the case of *R v Amrouchi*, [2007] EWCA Crim 3019, which re-iterates that the decision to proceed in the doctor's absence should be exercised with "great caution and close regard to the overall fairness of the proceedings."

The Panel has borne in mind that fairness to the doctor is of prime importance, although fairness to the GMC should also be taken into account. It has taken account of the effect of any delay on the quality of the evidence, the fact that witnesses have arranged to attend and give evidence before it, and the need to protect patients and the public interest.

In reaching its decision the Panel has balanced Dr Nowak's own interests with the public interest. It notes that Dr Nowak has engaged with the GMC throughout the pre-hearing case management and has indicated that he may not attend or may only attend for one day. He has been sent all the documentation on which the GMC seeks to rely. He has been asked to confirm in writing whether or not he intends to be present at these proceedings or when, but has not done so.

It is clear from the Notice of Hearing that Dr Nowak is aware that the Panel has the power to hear and decide upon the allegation in his absence and that this may lead to action being taken in respect of his registration. It also informed Dr Nowak of his right to apply for an adjournment, but no such request had been made.

The Panel is satisfied that that Dr Nowak has been given sufficient opportunity to attend the hearing in person. However he has made an informed decision and has voluntarily waived his right to attend this hearing and/or be represented. The Panel has borne the public interest in hearing this case without further delay. Further, the Panel considers that were it to adjourn today, there is no indication that Dr Nowak would attend a future hearing.

The Panel is conscious of its duty to ensure that the hearing will be fair. This is a professional Panel well able to explore all aspects of the case with the witnesses and act in fairness to all parties. In all the circumstances, and particularly in the public interest, the Panel has concluded that it is fair, reasonable and in the interests of justice to proceed with the hearing in Dr Nowak's absence. It is in the public interest that the Panel hears expeditiously matters which come before it. The Panel will draw no adverse inference from Dr Nowak's non-attendance at the hearing."

Determination on facts

Mr McDonagh: During proceedings the Panel allowed an application to accept written witness statements as evidence in-chief. It also allowed an application to hear evidence from some witnesses at Antrim Hospital via video-link. In reaching its decisions the Panel noted that Dr Nowak agreed to both matters during his participation in the pre-hearing telephone conferences with the Medical Practitioners Tribunal Service (MPTS) and the General Medical Council (GMC).

Furthermore, the Panel allowed an application to accept a report from Dr D (Clinical Director at the material time), who is now deceased, as 'hearsay evidence'. This was provided as an appendix to a witness statement from Dr E, Medical Director. The Panel considered this application in the light of the advice given by the Legal Assessor and the relevant legal authorities.

The Panel has given consideration to all the evidence adduced in this case, and to the submissions you have made on behalf of the GMC.

In relation to the burden and standard of proof, the Panel accepted the Legal Assessor's advice that the burden of proof rests on the GMC and that the standard of proof to be applied is the civil standard. Therefore where facts are in dispute the

Panel needed to decide which version is more likely than not to be correct. He also advised that the Panel is entitled to draw inferences from the evidence it has heard. In relation to the expert evidence of Dr F, the Legal Assessor advised that a witness called as an expert is entitled to express an opinion in respect of his findings on the matters which are put to him. The Panel is entitled to have regard to the opinions expressed by an expert when coming to its own conclusions about those aspects of the case.

In relation to the 'hearsay evidence' of Dr D, the Legal Assessor advised that as a matter of law, what Dr D said in his report about his conversations with Dr Nowak after the relevant incidents, and the actions that Dr D took in relation to those incidents, is admissible as hearsay evidence in view of the fact that Dr D is now deceased. However, the Panel needed to exercise caution when considering how reliable it found those parts of Dr D's report as evidence of matters of fact. It is inevitable that the document the Panel has is only a short synopsis of the discussions between the two doctors, and was not prepared for the purposes of this hearing.

The Legal Assessor drew the Panel's attention to Paragraph 2 of Good Medical Practice 2006 which sets out factors that good clinical care must include. He also advised the Panel that the terms 'inappropriately' or "adequately" should be given their ordinary everyday definition.

The Panel heard from a number of witnesses who were employed at the Antrim Hospital at the material time. The Panel found Dr G, the Registrar ST5, to be a credible, honest and reliable witness. During his evidence he expressed his concern regarding patient safety and how upset he had been at the time of the incident relating to Patient A.

The Panel found the evidence of Nurse H to be of limited assistance as she did not have a clear recollection of the incident relating to Patient A. In particular she was unable to recall whether Dr Nowak had been present in theatre.

The Panel found Nurse I to be a credible and honest witness who had a clear recollection of the incident relating to Patient B.

The Panel found Staff Nurse J to be a credible and reliable witness. She had a clear recollection of the incident relating to Patient C, appeared knowledgeable and was able to recall specific details.

The Panel found Dr K, Consultant Anaesthetist, to be an honest and credible witness who gave factual evidence. She had a clear recollection of her involvement in all three incidents and would not be drawn into speculation.

The Panel found Dr L, Consultant Anaesthetist to be a credible witness who was able to give an indication of Dr Nowak's attitude and manner during his employment at the Antrim Hospital.

The Panel found Dr F, the GMC Expert witness to be a credible and reliable witness. He gave detailed evidence about matters within his expertise as an anaesthetist, and how he viewed the circumstances of the incidents being considered by the Panel. He would not be drawn into speculation on the issues under consideration.

The Panel has considered each allegation separately. Accordingly, it has made the following findings on the facts:

Paragraph 1:

> "In the period 1 June 2010 to 19 November 2010 you were employed by the Northern Health and Social Care Trust as a Locum Consultant Anaesthetist and were based at Antrim Hospital."

has been found proved.

The Panel has been provided with a copy of the GMC Employer Details Form, completed by Dr Nowak and received by the GMC on 20 January 2011, confirming his dates of employment at Antrim Hospital. It has also had regard to the statement provided by Ms M, who at the time, was the Assistant Director of Elective and Acute Care at Antrim Hospital. She confirmed that Dr Nowak was employed as a Locum Consultant Anaesthetist.

First Incident 31 August 2010

Paragraph 2a:

> "You failed to provide good clinical care to Patient A in that at the time of her spinal anaesthetic procedure you absented yourself from the delivery suite."

has been found proved.

The Panel has been informed that on 31 August 2010 Dr Nowak was allocated to the Labour Ward and was called upon to administer Patient A's epidural. A decision was subsequently made that the patient needed an emergency caesarean section. The epidural was topped up by Dr Nowak in the delivery suite and Patient A was transferred to theatre.

The Panel heard evidence from Dr G who was worked with Dr Nowak, although he had not been present when Dr Nowak had administered the initial epidural. As the epidural had proved ineffective it was decided that Patient A should be provided with spinal anaesthesia. It was Dr G's evidence that Dr Nowak had agreed to allow him to do the spinal anaesthesia under his supervision.

Dr G informed the Panel that Patient A was a high risk patient due to her high body mass index, limited mouth opening and the recent epidural.

Dr G told the Panel that in complicated cases with a high risk patient it is desirable to have a 'second pair of hands' to assist should the need arise. He therefore expected

Dr Nowak to remain in theatre. However, by the time Dr G had established the spinal block he noticed that Dr Nowak had left the theatre.

It was Dr G's evidence that a few minutes after he had carried out the spinal anaesthesia complications arose. Patient A's oxygen saturation levels began to drop and she complained that she was having difficulties breathing and was losing her voice. He explained that a complication of spinal anaesthesia known as 'high spinal', can cause the patient difficulties in breathing.

Dr K told the Panel that she felt that, given Dr G's experience, he could have performed the procedure alone.

Dr F, GMC Expert was of the view that Dr Nowak would not necessarily have needed to be present but this was dependent on what Dr G had requested of his supervising consultant. Dr F indicated that 'high spinal' is a recognised complication. Although it is not common it is something that should be known to an anaesthetist supervising this type of procedure.

The Panel accepts Dr G's evidence that he asked Dr Nowak to supervise him whilst he carried out the spinal anaesthetic procedure. This request and the fact the patient was high risk required Dr Nowak to remain in theatre with Dr G and the patient. Despite this Dr Nowak left the delivery room for a significant length of time.

Dr Nowak should have been aware that this patient was high risk. By absenting himself from the theatre, and therefore not being present to assist if any complications arose, Dr Nowak failed to provide good clinical care to Patient A.

Paragraph 2b:

> "You failed to provide good clinical care to Patient A in that at the time of her spinal anaesthetic procedure you did not inform staff of your location when absent."

has been found proved.

The Panel accepts the evidence of Dr G that Dr Nowak did not inform him he was leaving the theatre or tell him where he would be. As the supervising consultant Dr Nowak had a duty to this patient. He failed to provide 'good medical care' for her by not advising staff of his whereabouts, because that created difficulties in the event of any complications requiring the attendance of a supervising consultant anaesthetist.

Paragraph 2c:

> "You failed to provide good clinical care to Patient A in that at the time of her spinal anaesthetic procedure you were not immediately contactable by staff
>
> i. in case of a complication arising,
>
> ii. when a complication did arise."

has been found not proved.

Dr G told the Panel that when complications arose he asked staff to bleep Dr Nowak and Dr K. The Panel has considered the medical notes and the entry made by Nurse H at 11:20 'Dr G asked that Dr K be bleeped' and at 11:24 'Dr K bleeped by Sister Harper.'

Nurse H was unable to recall clearly whether Dr Nowak had been bleeped at the same time as Dr K or not.

It was common ground that Dr K responded to the bleep immediately and assisted Dr G to stabilise the patient. However, no evidence was provided to show that Dr Nowak was bleeped. The Panel cannot be satisfied that Dr Nowak was not immediately contactable.

Paragraph 2d:

> "You failed to provide good clinical care to Patient A in that at the time of her spinal anaesthetic procedure you did not return to the delivery suite until after the patient was stabilised."

has been found proved.

The Panel has already found that Dr Nowak absented himself from the theatre during which time a complication arose in a high risk patient. The Panel is not aware of the precise period of time Dr Nowak absented himself from theatre but considers that this would have been considerable given Dr K's evidence that she responded to the bleep whilst she had been in the general theatre and that it would have taken her approximately three minutes to walk to the delivery theatre. She attended the delivery suite and stabilised the patient before Dr Nowak returned.

The Panel is satisfied that in the circumstances Dr Nowak failed to provide good clinical care to Patient A. He absented himself for such a period of time that the patient had to be attended to by another consultant from another part of the hospital.

Paragraph 3a:

> "Following your treatment of Patient A you acted inappropriately towards Dr G by grabbing his arm."

has been found proved.

The Panel accepted Dr G's evidence that he was outside the main theatres when he was approached by Dr Nowak, who in his opinion was very angry, and that Dr Nowak grabbed his forearm firmly. This is supported by the account he gave to Dr D following the incident.

The Panel is satisfied that Dr Nowak's actions in this regard were inappropriate. It accepts Dr F's evidence that it was a wholly unnecessary way for a senior supervising doctor to behave towards a junior colleague in these circumstances.

Paragraph 3b:

> "Following your treatment of Patient A you acted inappropriately towards Dr G by attempting to drag him into a delivery suite."

has been found not proved.

It was Dr G's evidence that Dr Nowak was of a larger physical build than him but despite this he did not move position when Dr Nowak took hold of him. The Panel has concluded that had Dr Nowak attempted to drag Dr G to the delivery suite it would not have been possible for Dr G to remain static.

Paragraph 3c:

> "Following your treatment of Patient A you acted inappropriately towards Dr G by saying words to the effect of, "What have you said to the Sister" and "Let's go back and speak to her."

has been found proved.

Dr G maintained in his two witness statements and evidence to the Panel that Dr Nowak did speak to him in the manner alleged. Given Dr G's evidence that Dr Nowak appeared angry and in the light of the Panel's finding that Dr Nowak grabbed Dr G's arm, the Panel is satisfied that it was inappropriate for Dr Nowak, as the supervising consultant, to speak to a junior member of staff in this way. The Panel also considers that it would be inappropriate and unprofessional for a supervising consultant to compel a trainee to take part in a confrontational meeting with a nursing sister.

Second Incident 15 October 2010

Paragraph 4a:

> "You failed to provide good clinical care to Patient B in that you did not make and/or record an adequate pre-operative assessment of Patient B."

has been found proved.

Patient B was admitted to Antrim Hospital on 15 October 2010 for an elective operation of intravesical botulinum injections because of longstanding urinary problems.

The Panel could not be satisfied, in the absence of any evidence dealing with the conduct of a pre-operative assessment, that Dr Nowak failed to make an adequate pre-operative assessment of Patient B. However, in the light of Dr F's evidence that

it is just as important to record negative as well as positive findings, it is satisfied that Dr Nowak did not make an adequate record of any pre-operative assessment.

The Panel has had regard to the GMC's guidance 'Good Medical Practice' (November 2006) which states at paragraph 3:

> "In providing care you must keep clear, accurate and legible records."

and

> "Make records at the same time as the events you are recording or as soon as possible afterwards."

The Panel considers that Dr Nowak did not adhere to this guidance and therefore it is satisfied that he failed to provide good clinical care to Patient B.

Paragraph 4b:

> "You failed to provide good clinical care to Patient B in that you administered to Patient B both Parecoxib and Voltarol ("the drugs") at approximately the same time."

has been found proved

The Panel has had regard to the witness statement and oral evidence provided by Sister I, Band 6 Sister in Recovery. She stated that Dr Nowak brought Patient B into the recovery area following the procedure. On reading the anaesthetic record she noticed that Dr Nowak had administered two non-steroidal anti-inflammatory drugs (NSAIDs) to Patient B peri-operatively, Parecoxib 40mgs intravenously and Voltarol 100mgs (also known as Diclofenac) per rectum. This is supported by the medical records.

The Panel accepted the clear evidence of Dr F and the other clinicians involved that these drugs should not be given together given the recognised side effects and increased risk of complications. By administering the drugs together to Patient B Dr Nowak failed to provide good clinical care because he increased the risks to which the patient was exposed.

Paragraph 4c:

> "You failed to provide good clinical care to Patient B in that you did not possess adequate knowledge of the pharmacology of the drugs."

has been found proved

The Panel accepts of the basis of the evidence of Sister I and the report provided by Dr D that Dr Nowak did not possess the adequate knowledge of the pharmacology of the drugs. The Panel considered that this lack of knowledge was clearly demonstrated by his insistence that the giving of the two drugs was not a problem. There was therefore a failure to provide good clinical care because Dr Nowak's lack of pharmacological knowledge exposed the patient to unnecessary risk.

Paragraph 4d:

"You failed to provide good clinical care to Patient B in that you failed to respond adequately to the concerns of a nursing colleague."

has been found proved

The Panel has not been provided with any evidence that Dr Nowak took notice of the concerns raised by Sister I. In her written statement she stated that when she raised her concern Dr Nowak responded that he believed that, as the drugs were different, it was 'okay' to administer them at the same time.

Dr F explained that he would have expected, at the very least, Dr Nowak to have obtained a second opinion, however there is no evidence that he did so.

The Panel is satisfied that, on the basis of the evidence, Dr Nowak failed to provide good clinical care to Patient B by failing to respond to concerns which were properly raised by a nursing colleague.

Paragraph 4e:

"You failed to provide good clinical care to Patient B in that you prescribed Patient B paracetamol at a level exceeding that which is recommended."

has been found proved

The Panel has had regard to Patient B's medical records in which Dr Nowak has recorded the potential dosage of paracetamol as 9 grams in 24 hours. It accepts the evidence of Dr F that maximum recommended daily dosage is 4 grams in 24 hours.

The Panel is satisfied that Dr Nowak prescribed an excessive paracetamol dosage. In doing so he failed to provide good clinical care to Patient B because of the risks associated with prescribing drugs in excess of the maximum recommended dosage.

<u>Third incident 20 October 2010</u>

Paragraph 5a:

"You failed to provide good clinical care to Patient C in that you did not make and/or record an adequate pre-operative assessment of Patient C."

has been found proved.

Patient C was admitted to Antrim Hospital on 20 October 2010 for a circumcision. Dr Nowak was the anaesthetist attending the patient. The medical notes support that Dr Nowak did carry out a pre-operative assessment of the patient in which he recorded that the patient's hypertension, blood pressure and heart rate. The Panel however finds that this assessment was inadequate because Dr Nowak failed to record that the patient was asthmatic or to record any drug history. The Panel notes

that this is documented very clearly in a previous pre-operative assessment completed on 28 January 2010. The Panel also noted the difference in the Mallampati score recorded in January 2010 as '4' and in Dr Nowak's records in October 2010 as '1'. It has therefore concluded that Dr Nowak's pre-operative assessment could not have included an adequate assessment of the patient's medical records.

In all the circumstances the Panel is satisfied that Dr Nowak failed to provide good clinical care as he did not make or record an adequate pre-operative assessment.

Paragraph 5b:

> "You failed to provide good clinical care to Patient C in that you did not recognise and/or adequately act upon the deterioration in Patient C."

has been found proved.

It was Staff Nurse J's evidence that there was a dramatic drop in Patient C's oxygen saturation levels at the beginning of the surgical procedure. However, several witnesses stated that Dr Nowak did not appear to recognise that there was a significant problem and that he maintained that everything was 'okay'. The evidence of Dr F was that a drop in oxygen saturation levels is potentially catastrophic for the patient. Dr Nowak's failure to recognise a deteriorating clinical situation and act upon it was a serious departure from the duty to provide good clinical care for a patient.

Paragraph 5c:

> "You failed to provide good clinical care to Patient C in that you did not recognise the onset of anaphylaxis and/or adequately manage Patient C's condition."

has been found proved.

The Panel has had regard to the written statement and oral evidence provided by Dr K who, on hearing the alarm bell sound, attended to assist.

Dr K told the Panel that it soon became clear to her that the patient was very unstable. Patient C was hypoxic with an oxygen saturation level around 70%. Despite this Dr Nowak was still ventilating on the mechanical ventilator with a mixture of air, oxygen and nitrous oxide. As Dr Nowak did not give her any communication as to what he thought the problem was and he was taking no action to treat the hypoxia she called for further assistance to resuscitate the patient. She told the Panel that her primary concern was patient safety and as she considered the situation a 'critical medical emergency' she and another colleague took over the subsequent management, resuscitation and stabilisation of the patient.

Dr F told the Panel that when faced with a deteriorating patient Dr Nowak should have responded by adopting the '4 point rescue strategy', including the recognition that the deterioration could have been due to the onset of anaphylaxis. Dr F was of the view that an anaesthetist of any grade should have been able to recognise this.

The Panel is satisfied, on the basis of the evidence, that Dr Nowak did not recognise the onset of anaphylaxis or adequately manage Patient C's condition. This amounts to a failure to provide good clinical care as such a condition should have been recognised by an anaesthetist and the seriousness of the condition can plainly have disastrous effects for the patient.

Paragraph 5d:

> "You failed to provide good clinical care to Patient C in that you did not call for assistance."

has been found proved.

The Panel has had regard to the patient's medical records in which Dr Nowak recorded that he had called for help. However, the Panel found this to be inconsistent with the evidence given by Staff Nurse J and Dr K who both agreed that Dr Nowak had maintained that everything was 'okay'.

The Panel considers it unlikely that Dr Nowak would have called for assistance and then told those who attended that everything was 'okay'. It is satisfied that in not calling for assistance he failed to provide good clinical care to Patient C for the same reasons as those set out in relation to paragraph 5C.

Paragraph 5e:

> "You failed to provide good clinical care to Patient C in that you attempted to dismiss the help of anaesthetic colleagues."

has been found proved

The Panel accepted the evidence of Staff Nurse J and Dr K that Dr Nowak maintained that everything was 'okay' indicating that he did not require assistance. It is therefore satisfied that he attempted to dismiss the help of anaesthetic colleagues. In doing so he failed to provide good clinical care to Patient C because this was a situation in which help was clearly needed to deal with the sudden and rapid life threatening deterioration in Patient C's condition under anaesthetic.

Having reached findings on the facts, the Panel now invites you to make submissions as to whether, on the basis of the facts found proved, Dr Nowak's fitness to practise is impaired by reason of his misconduct.

Determination on impaired fitness to practise

Mr McDonagh: Having announced its findings on the facts, the Panel has now considered whether, on the basis of the facts found proved, Dr Nowak's fitness to practise is impaired by reason of misconduct. The Panel has taken into account all the evidence before it and the submissions you have made on behalf of the General Medical Council (GMC).

GMC Submissions

You took the Panel through its findings on the facts and extensively referred it to the relevant sections of Good Medical Practice (November 2006). You submitted that Dr Nowak's actions in relation to the three patients and his interaction with Dr G fell seriously below the standards expected of a Consultant Anaesthetist and constitute a serious departure from Good Medical Practice. You submitted that Dr Nowak's behaviour presented a risk to patient safety and the third incident, by itself, constituted a serious departure from the standards expected. You submitted that serious misconduct was present.

You drew the Panel's attention to the observations made in Meadow v GMC [2006] EWCA CIV 1390, which advises a Panel to consider the issue of fitness to practise by looking forward, although it is entitled to take account of the way in which the person concerned has acted or failed to act in the past.

You accepted that no adverse inference should be drawn from Dr Nowak's absence from this hearing. However, you submitted that he has not provided any written submissions and therefore the Panel has no evidence of any insight or remediation undertaken to address the concerns raised. You submitted that there is some material which may be in Dr Nowak's favour. You drew the Panel's attention to his curriculum vitae which demonstrates employment for a number of years, including in the UK, with no evidence of any difficulty. Furthermore, there is evidence that colleagues at Antrim Hospital were initially willing to work with Dr Nowak to address the concerns raised rather than stopping him practising or terminating his contract.

However, you submitted that the failings identified, especially in relation to Patient C, were fundamental, serious and could have led to catastrophic outcomes. The failings were described by Dr F, the GMC Expert, as 'gross' and 'dangerous'. You submitted that in light of the criticisms of Dr Nowak's practice and lack of evidence of any remediation Dr Nowak's fitness to practise is impaired by reason of his misconduct.

Advice of the Legal Assessor

The Legal Assessor advised the Panel that each case turns on its own facts and a finding of impairment does not necessarily follow from a finding of misconduct. He referred the Panel to a number of judgments relevant to its consideration at this stage of proceedings including Paragraph 74 of the judgment in the case of CHRE v NMC & Grant [2011] EWHC 927 (Admin), which states:

> 'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'

The Legal Assessor also referred the Panel to the reasons why a Panel might find impairment of fitness to practise as outlined by Dame Janet Smith in her fifth Shipman report. These are listed as follows:

> "(a) that the doctor presented a risk to patients, (b) that the doctor had brought the profession into disrepute, (c) that the doctor had breached one of the fundamental tenets of the profession and (d) that the doctor's integrity could not be relied upon."

The Legal Assessor advised that the Panel should not hold Dr Nowak's absence against him and also should consider material which may be in Dr Nowak's favour.

The Panel's decision

Throughout its deliberations, the Panel has borne in mind its responsibility to protect the public interest. The public interest includes not only the protection of patients but also the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour.

Whilst the Panel has borne in mind the submissions made, the issue of impairment is one for it to determine exercising its own judgment.

The Panel has followed the two step process set out in Cheatle v GMC [2009]. First, the Panel must determine whether the facts found proved amount to misconduct that is serious. If so the Panel must then decide whether, in all the circumstances, Dr Nowak's fitness to practise is currently impaired as a result of that misconduct. In reaching that decision the Panel is entitled to take into account a doctor's conduct since the events in question, and any action a doctor has taken to remedy any deficiencies in his or her practice.

The Panel notes that in the period 1 June 2010 to 19 November 2010 Dr Nowak was employed by the Northern Health and Social Care Trust as a Locum Consultant Anaesthetist, based at Antrim Hospital. The facts found proved relate to his failure to provide good clinical care to three patients and his inappropriate behaviour towards a junior member of staff.

In relation to Patient A, the Panel found that Dr Nowak absented himself from the delivery suite at the time of Patient A's spinal anaesthetic procedure and did not inform staff of his location when absent or return to the delivery suite until after the patient had been stabilised.

The Panel also found that following the incident Dr Nowak acted inappropriately toward Dr G, a junior colleague under his supervision, by grabbing his arm and saying words to the effect of, "What have you said to the Sister" and "Let's go back and speak to her."

In relation to Patient B, the Panel found that Dr Nowak did not make an adequate record of a pre-operative assessment. He administered Parecoxib and Voltarol to the patient under general anaesthesia at approximately the same time; did not possess

adequate knowledge of the pharmacology of the drugs and failed to respond to the concerns of nursing colleagues. Furthermore, he prescribed paracetamol at a level exceeding that recommended.

In relation to Patient C, the Panel found that Dr Nowak did not make or record an adequate pre-operative assessment. He did not recognise or adequately act upon the deterioration in Patient C's condition; he did not recognise the onset of anaphylaxis or adequately manage the Patient's condition. Furthermore, he did not call for assistance and attempted to dismiss the help of anaesthetist colleagues.

Misconduct

The Panel has borne in mind the principles contained within the GMC's publication Good Medical Practice (November 2006), which was applicable at the time:

Paragraph 1 states:

> "Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues..."

Paragraph 2 states:

> "Good clinical care must include:
>
> a. adequately assessing the patient's conditions, taking account of the history(including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient
>
> b. providing or arranging advice, investigations or treatment where necessary."

Paragraph 3 states:

> "In providing care you must:
>
> f. keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment
>
> h. be readily accessible when you are on duty;
>
> i. consult and take advice from colleagues, where appropriate."

Paragraphs 16 and 17 under the heading of 'Teaching and training, appraising and assessing' state:

> "If you are involved in teaching you must develop the skills, attitudes and practices of a competent teacher.
>
> You must make sure that all staff for whom you are responsible, including locums and students, are properly supervised."

Paragraph 41 under the heading of 'Working in teams' states:

> "You must
>
> a. respect the skills and contributions of your colleagues."

Paragraph 46 under the heading of 'Respect for colleagues' states:

> "You must treat your colleagues fairly and with respect…"

The Panel is satisfied that Dr Nowak's conduct clearly breached this guidance.

In relation to Patient A, the Panel considers that Dr Nowak's actions, in absenting himself from the theatre when he had been asked by Dr G, a junior colleague, to supervise the procedure and not advising of his location put the patient at significant risk. Dr Nowak should have been aware that this was a high risk patient and of the potential complications associated with this. The Panel considers that Dr Nowak had a clear responsibility as the supervising consultant to ensure that Patient A was receiving adequate care. He had not worked with Dr G previously and therefore may have been unaware of Dr G's level of experience. In the circumstances he should have been providing a higher level of supervision. The Panel is therefore satisfied that Dr Nowak's failure to provide good clinical care to Patient A constitutes serious misconduct.

The Panel has considered Dr Nowak's behaviour towards Dr G. Although it accepts that the incident was not so serious as to amount to serious misconduct on its own, it is of the view that it is not appropriate for a supervising consultant to behave in this way towards a junior member of staff. This was not an isolated incident, as the Panel has evidence on two separate occasions of Dr Nowak's dismissive behaviour towards other colleagues. The Panel therefore considers that looking at the overall circumstances this part of Dr Nowak's behaviour constitutes serious misconduct.

Dr Nowak attended Patient B as an anaesthetist. He gave her analgesic drugs which should not be given together. He also gave her a prescription for paracetamol that was more than double the recommended daily dosage. The error in respect of the analgesic drugs was noticed by a nurse who pointed it out to Dr Nowak. Despite this he maintained that the giving of the two drugs at the same time was not a problem. It is clear therefore that he did not understand the pharmacology of these drugs nor did he react appropriately to the concerns of a nursing colleague. The Panel considers that this lack of knowledge in a doctor of consultant anaesthetist grade and failure to react appropriately is a serious deficit. Patient B had attended for a minor procedure involving minimum risk but this risk was significantly increased by Dr Nowak's actions which the Panel finds amounts to serious misconduct.

The Panel is particularly concerned by Dr Nowak's actions in relation to Patient C. He failed to carry out an adequate pre-operative assessment and therefore was not aware that the patient was asthmatic. Dr Nowak failed to recognise the onset of anaphylaxis, a potentially life threatening condition. He failed to take proper action to address the rapidly deteriorating situation of this patient in that he did not undertake the necessary emergency intervention. He should have given the patient

100% oxygen when the patient's oxygen levels fell dangerously low. He failed to do this despite being given correct advice by Staff Nurse J. He then continued to dismiss the help that was offered by the consultant anaesthetist who responded to the emergency call. It was only the intervention of other colleagues that averted the possibility of brain damage or death.

The Panel accepted the opinion of Dr F that the recognition of the onset of anaphylaxis is basic knowledge for an anaesthetist, at any level. It considers that anticipating, pre-empting, recognising and managing difficulty in ventilation is one of the most basic responsibilities of an anaesthetist given the potential for complications. The Panel considers that Dr Nowak's failure to provide good clinical care to Patient C constitutes serious misconduct.

The Panel went on to consider whether Dr Nowak's fitness to practise is impaired as a result of his misconduct.

The Panel has taken account of the need to protect patients and the wider public interest including the maintenance of public confidence in the profession, and the declaring and upholding of proper standards of conduct and behaviour. It has borne in mind that impairment does not necessarily follow from a finding of misconduct and that, in accordance with the judgment in the case of Cohen [2008] EWHC 581 (Admin), the Panel should consider the issues of remediation, insight and the risk of recurrence in determining whether misconduct should lead to a finding of impaired fitness to practice.

Whilst the Panel has considered each incident separately, it is satisfied that there is a pattern of behaviour demonstrating a failure to make and record appropriate pre-operative assessments, a lack of knowledge, a lack of ability and a failure to establish and maintain good relationships with colleagues. The Panel is satisfied that Dr Nowak's actions fell seriously below the standard expected of a reasonably competent consultant anaesthetist and constitute a disregard for patient safety.

The Panel has not been provided with any evidence of any remediation undertaken by Dr Nowak to address the concerns raised. The Panel has had regard to the report from Dr D in which he refers to the incident with Patient C and his concern that Dr Nowak demonstrated no insight into the seriousness of his failings. It appears to this Panel that Dr Nowak has no insight into the concerns raised.

In the circumstances the Panel cannot be satisfied that the misconduct will not be repeated. It considers there to be a continuing risk to patient safety and has therefore determined that Dr Nowak's fitness to practise is impaired by reason of his misconduct, pursuant to Section 35C(2)(a) of the Medical Act 1983, as amended.

The Panel will now invite you to make submissions as to the appropriate sanction, if any, to be imposed on Dr Nowak's registration. Submissions on sanction should include reference to the current Indicative Sanctions Guidance, using the criteria set out in the guidance to draw attention to the issues which appear relevant in this case.

Determination on sanction

Mr McDonagh: Having determined that Dr Nowak's fitness to practise is impaired by reason of his misconduct, the Panel has considered the submissions you have made, on behalf of the General Medical Council (GMC), regarding the appropriate sanction, if any, that should be imposed on Dr Nowak's registration.

You drew the Panel's attention to the relevant paragraphs of the current Indicative Sanctions Guidance (ISG) and submitted that the appropriate sanction in this case is one of erasure.

You drew the Panel's attention to the aggravating and mitigating factors in this case. You submitted that the circumstances of this case dictate that action has to be taken on Dr Nowak's registration. You argued that Dr Nowak's misconduct involved three separate incidents of poor patient care and therefore cannot be considered as a single clinical incident. You further submitted that, given the lack of evidence of insight and willingness to remediate, conditions would not be appropriate to ensure patient safety. On the other hand, you submitted that Dr Nowak appeared to have an employment history in the UK which had been problem free and colleagues at Antrim Hospital had initially been prepared to work with him to address any failings in his practice.

You reminded the Panel of its findings and submitted that Dr Nowak's misconduct represents a particularly serious departure from the principles set out in Good Medical Practice. Furthermore, in the absence of any evidence of insight or remediation, there remains the concern of a repetition of such misconduct. You submitted that Dr Nowak's conduct falls so far short of the standards expected that it is fundamentally incompatible with continued registration. Therefore a period of suspension would be inappropriate.

In reaching its decision the Panel has taken account of the ISG and is aware that the decision as to the appropriate sanction, if any, to impose on Dr Nowak's registration is a matter for this Panel exercising its own independent judgment. Also, that it must start with the least restrictive sanction and work upwards.

The Panel has considered whether it is necessary for the protection of members of the public, in the public interest or in Dr Nowak's own interests to make a direction in relation to his registration. In doing so it has balanced the public interest against his own interests and has taken into account the principle of proportionality.

The Panel has borne in mind its duty to protect the public, to maintain public confidence in the medical profession, and to uphold proper standards of conduct and behaviour as set out in the GMC's document "Good Medical Practice".

The Panel first considered whether to conclude Dr Nowak's case and take no further action, but determined that in view of the serious nature of his misconduct this course of action would be insufficient and, therefore, inappropriate.

The Panel next considered whether it would be appropriate to impose a period of conditions on Dr Nowak's registration. It has borne in mind that any conditions must be appropriate, proportionate, workable and measurable.

The Panel has not been provided with any positive evidence of Dr Nowak's willingness or ability, at present, to remedy the concerns raised. It has therefore determined that conditions would not be the appropriate or proportionate sanction neither would they reflect the seriousness of Dr Nowak's misconduct.

The Panel then considered whether it would be sufficient to suspend Dr Nowak's registration.

The Panel has taken account of paragraphs 69 and 70 of the Indicative Sanctions Guidance which state that:

> "69. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner. Suspension has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension. Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession.
>
> 70. Suspension is also likely to be appropriate in a case of deficient performance in which the doctor currently poses a risk of harm to patients but where there is evidence that he/she has gained insight into the deficiencies and has the potential to be rehabilitated if prepared to undergo a rehabilitation programme. In such cases, to protect patients and the public interest, the panel might wish to impose a period of suspension, direct a review hearing and to indicate in broad terms the type of remedial action which, if undertaken during the period of suspension, may help the Panel's evaluation at any subsequent review hearing."

It has also taken into account paragraph 75, which indicates when suspension might be appropriate.

The Panel has already determined that Dr Nowak's misconduct constitutes a serious breach of Good Medical Practice and fell seriously below the standard expected of a reasonably competent consultant anaesthetist. It considers that the misconduct found raises significant concerns regarding Dr Nowak's professional competence.

The Panel notes that Dr Nowak engaged with the pre-hearing process and participated in the scheduled telephone conferences with the Medical Practitioners Tribunal Service (MPTS) and the General Medical Council (GMC). He indicated that he may attend the hearing for one day and would provide written submissions for this Panel's consideration, but he did not do so. Although Dr Nowak has been given every opportunity to participate in this hearing, the Panel is puzzled as to why he

appears to have suddenly disengaged from the disciplinary process shortly before the start of this hearing.

The Panel accepts that it cannot draw any inference from Dr Nowak's absence. However, it is concerned that Dr Nowak has not provided any evidence of his insight into his misconduct, willingness to remedy the concerns raised or of what steps, if any, he has taken to remediate.

The Panel has given careful consideration to the issue of Dr Nowak's insight but in the absence of any direct evidence it has had difficulty gauging this. In its determination on impairment the Panel commented, on the basis of the late Dr D's report, that Dr Nowak appears to have no insight into the concerns raised. However, the Panel has not had the opportunity to explore this point. The Panel notes that in Dr D's report he stated that in Dr Nowak's first few months of employment at Antrim Hospital he worked to a reasonably satisfactory level, and his locum contract was extended for a further 12 months. Dr L stated that although he had found Dr Nowak 'brusque' he had initially been prepared to work with him to address the concerns raised. The Panel heard from Dr K that she had no concerns regarding Dr Nowak's attitude.

Dr Nowak initially qualified as an anaesthetist in Poland in 1984. He then appears to have practised as an anaesthetist in the UK from 2005 without any difficulties. This suggests he has the capacity to remediate.

In all the circumstances the Panel does not consider that Dr Nowak's actions are fundamentally incompatible with him continuing to be a registered doctor. The Panel considers that a period of suspension is sufficient to send the right message to Dr Nowak and to the profession that his behaviour has been unacceptable. Furthermore that it will be sufficient to protect patients and maintain public confidence in the profession. The Panel considers that, given Dr Nowak's engagement with the pre-hearing process, it cannot rule out the potential for him to re-engage with his regulatory body and to address the deficiencies in his conduct which have led to these proceedings. If those deficiencies can be addressed satisfactorily, the public will not in the long term lose, through erasure from the Register, a doctor who can make a useful contribution in the future as a practising anaesthetist. In the circumstances it is satisfied that Dr Nowak should be afforded a further opportunity to provide evidence of his insight and remediation. The Panel has therefore determined to suspend his registration for a period of 12 months to allow him sufficient time to provide evidence of his insight and to take remedial action.

A Panel will review Dr Nowak's case at a hearing to be held before the end of the period of suspension. It will then consider whether it should take any further action in relation to his registration. Dr Nowak will be informed of the date of that meeting, which he will be expected to attend. The Panel reviewing his case will be assisted by receiving:

- Evidence that he has developed insight into his misconduct
- Evidence of remedial action he has taken

- Evidence of the efforts he has made to maintain and keep his medical knowledge up to date during the period of suspension.

- Any further information which may be relevant and assist the review Panel.

The effect of this direction is that, unless Dr Nowak exercises his right of appeal, this decision will take effect 28 days from when written notice of this determination is deemed to have been served upon him. A note explaining his right of appeal will be supplied to him.

Having reached a decision that Dr Nowak's registration should be suspended, the Panel now invites submissions from you, on behalf of the GMC, as to whether Dr Nowak's registration should be suspended with immediate effect.

Determination on immediate sanction

Mr McDonagh: Having determined that Dr Nowak's registration be suspended the Panel has now considered, in accordance with Section 38 of the Medical Act 1983, as amended, whether to impose an immediate order on his registration.

You referred to the Panel's determination on sanction and its description of the misconduct found proved as raising significant concerns in relation to Dr Nowak's professional competence. You also referred to the lack of evidence of insight. You submitted that in the circumstances an immediate order is necessary to protect patients.

The Panel has had regard to the Indicative Sanctions Guidance (ISG) and notes that it may impose an immediate order where it is satisfied that it is necessary for the protection of members of the public, or is in the public interest or is in the best interests of the practitioner.

It has particular regard to paragraph 123 of ISG, which states:

> "An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety, for example where he/she has provided poor clinical care (ie breached paragraphs 2 – 11, *Good Medical Practice*)..."

The Panel has determined that, given the concerns raised regarding patient safety, it is necessary for the protection of members of the public and in Dr Nowak's own interests, to prevent a repetition of his misconduct, to suspend his registration with immediate effect.

The substantive direction for suspension, as already announced, will take effect 28 days from when written notification is deemed to have been served upon Dr Nowak, unless an appeal is lodged in the interim. The order of immediate suspension will take effect when written notification is deemed to have been served and will remain in force until the substantive direction takes effect, or until such time as the outcome of any appeal is decided.

The interim order currently imposed on Dr Nowak's registration will be revoked when notice of this decision is deemed to have been served on him.

That concludes this case.

Confirmed

11 April 2013 Mr J Donnelly, Chairman