PUBLIC RECORD

Dates: 26/06/2023 – 14/07/2023; 08/08/2023; 11/08/2023; 15/04/2024 - 19/04/2024

Medical Practitioner's name:	Dr Claudia MARTINEZ HIGUEROS
GMC reference number:	7061578
Primary medical qualification:	Med y Cir 2000 Universidad de San Carlos

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome
Erasure
Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Claire Lindley
Lay Tribunal Member:	Mr John Kelly
Medical Tribunal Member:	Dr Barry Adams-Strump

Tribunal Clerk:	Mr Matt O'Reily 26/06/23– 17/07/23; 08/08/23 -08/08/23; 11/08/23 - 11/08/2023 Ms Fiona Johnston 15/04/24- 19/04/24

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Kwabena Owusu, Counsel 25/06/23 - 07/07/23 Doctor unrepresented 08/07/23 -14/07/23 Mr Markus Findlay, Counsel 11/08/23 Mr David Morris, Counsel, instructed by Clifford Johnston & Co 15/04/24 -19/04/24 2024
GMC Representative:	Ms Laura Barbour, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 11/08/2023

Background

1. Dr Martinez Higueros graduated in Madrid, Spain, with a BCh in General Medicine and Surgery in 2008. She completed a PhD in Clinical Trials at the University of London between 2010 and 2012. Dr Martinez Higueros also worked as a Clinical Lecturer and Fellow in Vascular and lnterventional Radiology at the Royal College of Surgeons of Ireland between July 2017 and June 2018. She was employed at Guys & St Thomas Foundation Hospital, London, as a Senior Clinical Fellow in Vascular and lnterventional Radiology, between June 2018 and February 2019. She then transferred to St George's University Hospital as an Honorary Fellow, until September 2020.

2. Dr Martinez Higueros worked as a locum Interventional Radiologist for the Chelsea and Westminster Hospital NHS Foundation Trust (the Trust) on a 6-month contract from September 2019 to February 2020. This was Dr Martinez Higueros's first consultant post, and therefore a decision was taken upon her arrival that she would be supervised.

3. Dr Martinez Higueros since worked as a Locum Consultant in Vascular and lnterventional Radiology at East Kent and Canterbury Hospitals between March 2020 and October 2020. She has been employed as a substantive Consultant lnterventionalist Radiologist at Northampton General Hospital NHS Trust, from October 2020 to present.

4. The Allegation arises out of Dr Martinez Higueros's care and treatment of Patients' A and B, whilst in her post as a locum Interventional Radiologist at the Chelsea and Westminster Hospital.

Patient A

5. A Serious Incident Report ('SUI') was raised about Dr Martinez Higueros's treatment of Patient A on 12 December 2019. In summary, that report set out that Patient A was a 73-year-old woman who attended the Emergency Department ('ED') on 10 December 2019 with a presenting complaint of worsening shortness of breath. She had a history of congestive cardiac failure and was unable to cope at home. She also had a history of breast cancer and

was admitted to the Acute Assessment Unit ('AAU') for optimisation of medication and investigation of new left pleural effusion.

6. Patient A underwent a CT scan of her chest, which confirmed a left sided pleural effusion. The medical team decided that an aspiration of left sided effusion would be undertaken for diagnostic reasons. A Medical Specialist Registrar was unable to perform the aspiration on the ward due to abnormal anatomy and Patient A's non-compliance and a decision was taken to request that the procedure be undertaken by an interventional radiologist.

7. It is alleged that on 11 December 2019, Dr Martinez Higueros was requested by Dr G to perform a diagnostic left pleural aspiration ('the aspiration') on Patient A but that on 12 December 2019, she performed a therapeutic right sided pleural drainage. It is also alleged that Dr Martinez Higueros did not obtain adequate clinical information to determine the intended purpose of the aspiration before undertaking the drainage or discuss the decision to change the procedure with the referring clinicians or another interventional radiology colleague.

8. It is alleged that Dr Martinez Higueros then failed to update or explain the reason for her decision to carry out the drainage during a ward meeting with colleagues later that day, and also failed to apologise to Patient A for performing the drainage rather than the aspiration.

9. After the ward meeting, Dr Martinez Higueros added an addendum to the Radiology Information System ('RIS') operative report stating, 'Medical team contacted.' When Dr Martinez Higueros made that addendum, it is alleged that she meant it to convey that she had contacted the medical team to discuss her decision to perform the drainage. It is alleged that she did not make that contact and that this action was therefore dishonest.

Patient B

10. A SUI was raised in respect of Dr Martinez Higueros's treatment of Patient B on 6 February 2020. In summary, that report set out that Patient B was a 58-year-old man who presented at the ED at the Hospital on 22 December 2019 with a 5-day history of frank haematuria, feeling nauseated and feverish. He had a history of renal stones.

11. On 7 January 2020, Patient B underwent a urogram CT scan which showed bilateral indeterminate renal cysts and it was recommended the patient have an MRI to determine the nature of these cysts.

12. Patient B's kidney MRI took place on the 15 January 2020 and was reported by Dr Martinez Higueros as showing a Bosniak 3 right upper renal cyst and a solid left lower pole lesion. Patient B then attended the urology outpatient clinic on 27 January 2020 where he was informed of the MRI results.

13. On the 29 January 2020, the patient's case was listed for a urology MDT (multi-disciplinary team) discussion. The radiologists reviewed the CT and MRI scans and agreed

that the left renal lesion was suspicious for malignancy and recommended biopsy. The outcome of this MDT was documented that the patient was waiting for a *"LEFT renal biopsy"* to take place in the Interventional Radiology (IR) Department.

14. Dr Martinez Higueros undertook the renal biopsy procedure on Patient B. In her report following the procedure she stated that *"US confirmed solid component of the upper right renal pole lesion"*, setting out that it was the right sided lesion that was biopsied. The histopathology report following the procedure also stated that the biopsy was from the right side, as opposed to the left side as agreed in the MDT of 29 January 2020.

15. It is therefore alleged that on 6 February 2020 Dr Martinez Higueros carried out a biopsy on Patient B's right kidney ('the biopsy'), when the request had been for a biopsy of the left kidney.

16. On 28 February 2020, Dr Martinez Higueros met with Dr C and Ms D ('the meeting'). It is alleged that she was dishonest in some of her responses during that meeting.

17. It is also alleged that on 28 February 2020, Dr Martinez Higueros made an addendum entry to a RIS Report stating, *"The solid lesion identified and biopsied is on the lower pole of the left kidney*". Further, that on or around 2 March 2020, she asked the histopathology department to amend the histopathology report for the Biopsy to state, "*Specimen location should be left renal lesion".* It is alleged that Dr Martinez Higueros knew that this information was untrue and that both these actions were therefore dishonest.

The Outcome of Applications Made during the Facts Stage

18. At the outset of the hearing, Ms Laura Barbour, Counsel, on behalf of the GMC, made an application to amend the Allegation, pursuant to Rule 17(6) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). Mr Kwabena Owusu, Counsel on behalf of Dr Martinez Higueros, opposed the application. The Tribunal determined to grant the application. The Tribunal's full written decision can be found at Annex A.

19. On Day 1 of the hearing, Mr Owusu made an application to adjourn the hearing until Wednesday 28 June 2023. Ms Barbour invited the Tribunal to sit in the morning on Tuesday 27 June 2023. The Tribunal determined to grant the application. The Tribunal's full written decision can also be found at Annex A.

20. On Day 10 of the hearing, after the close of the GMC case, a fifth witness statement was provided by Dr Martinez Higueros. Ms Barbour told the Tribunal that there was information in that statement which had not been put to Dr M, the GMC expert. She made an application to reopen the GMC case in order to obtain a further statement from Dr M so that the new matters could be considered and addressed by him. Mr Owusu made no objection, and the Tribunal granted the application. Time was granted, and a further statement obtained from the expert. The GMC case was reopened, the statement admitted, and then the case was closed again. However, on Day 11 of the hearing, Mr Owusu withdrew from the

case, and Dr Martinez Higueros continued unrepresented. The Doctor stated that she wanted to cross examine Dr M about the further statement that had been served in response to her fifth statement. This request differed from the stance that had been taken by her counsel when the statement was admitted without objection. In order to facilitate this request, Ms Barbour made another application to re-open the GMC case so that Dr M could be recalled. Dr Martinez Higueros made no objection, and the Tribunal granted the application.

21. The Legally Qualified Chair (LQC) set out the Tribunal Approach to both these requests:

22. The Tribunal was informed that Rule 17 of the Rules sets out the process for Tribunals to follow. That Rule does not expressly permit the GMC to open its case, once it has been closed, but neither does it prohibit it. The Tribunal considered the case of *Hill v Institute of Chartered accountants 2013 EWHC Civ 555* where LJ Longmore stated that it is not whether a part of the process is permitted, but whether it is prohibited.

23. The Tribunal was advised that reopening a case is within the court's discretion, and that the tests should be whether it is fair to grant the application and whether it is in the public interest to do so. It was advised that they should consider why the request was being made, at what stage of the proceedings, whether there was any prejudicial effect on the Doctor, and balancing that against fairness to the GMC.

24. The Tribunal was informed of the case of *R(DPP) v Chorley Justices and Andrew Forrest 2006 EWHC 1795* which states that the Court (in this case the Tribunal), when considering the interest of justice should take into account whether there has been an *"ambush defence"* – that being where the defence have raised an issue not mentioned earlier in the hearing or in the case management hearings.

25. The Tribunal was asked to note that there were no objections to either application to reopen the case.

26. The Tribunal considered the advice given and decided that it was fair to allow the GMC case to be reopened on both occasions, and that it was in the interests of justice to do so. There were no objections from Mr Owusu, or from the Doctor, and the requests were made because of a new statement served by the defence, and then because of the Doctor's request to cross examine the expert. The timing of the applications were such (i.e. before the defence case had started), that there was no prejudice caused to the Doctor.

The Allegation and the Doctor's Response

27. The Allegation made against Dr Martinez Higueros is as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. On 12 December 2019 you were requested by Dr G to perform a diagnostic left pleural aspiration ('the Aspiration') on Patient A but you performed a therapeutic right sided pleural drainage ('the Drainage'). Amended pursuant to Rule 17(6) / To be determined

2. ~~Your actions at Paragraph 1 were inappropriate because you failed to~~ Prior to undertaking the Drainage, you did not: Amended pursuant to Rule 17(6)

    a. obtain adequate clinical information to determine the intended purpose for the Aspiration, before undertaking the Drainage; Amended pursuant to Rule 17(6) / To be determined

    b. discuss the decision to change the procedure with the referring clinicians or another interventional radiology colleague before performing the Drainage; To be determined

    ~~c. engage with the clinical team in the interventional radiology theatre to ensure the accurate completion of the World Health Organisation preprocedural checklist;~~ Withdrawn pursuant to Rule 17(6)

    ~~d~~.c. perform the Aspiration as requested by Dr G;
    Amended pursuant to Rule 17(6) / To be determined

    ~~e. record your reasoning for carrying out the Drainage rather than the Aspiration;~~ Withdrawn pursuant to Rule 17(6)

    3. Following the Drainage, you failed to:

    ~~f.~~a. update your colleagues to explain your decision to carry out the Drainage; Amended pursuant to Rule 17(6) / To be determined

    ~~g~~.b. apologise to Patient A for performing the Drainage rather than the Aspiration, during the ward meeting at around 18:00. Amended pursuant to Rule 17(6) / To be determined

    ~~3.~~4. At around 19:28 on 12 December 2019, you added an addendum to the Radiology Information System ('RIS') operative report stating 'unable to perform left side drain insertion, as requested. Decision made on right sided drain insertion. Medical team contacted' ('the Amendment'). Amended pursuant to Rule 17(6) / To be determined

    ~~4~~.5. When you made the Amendment you knew that you had not contacted the medical team to discuss your decision to perform the Drainage. Amended pursuant to Rule 17(6) / To be determined

~~5.~~6. Your actions at paragraph ~~3~~4 were dishonest by reason of paragraph ~~4~~5. Amended pursuant to Rule 17(6) / To be determined

Patient B

~~6.~~7. On 6 February 2020 you carried out a biopsy on Patient B's right kidney ('the Biopsy'), on which you entered a RIS report ('the Report') stating 'US confirmed solid component of the upper right renal pole lesion'. Amended pursuant to Rule 17(6) / To be determined

~~7.~~8. On 28 February 2020 you: Amended pursuant to Rule 17(6)

a. were interviewed by Dr C and Ms D at around 09:45 and stated that the Biopsy was:

i. performed by Dr E; To be determined

ii. taken from the left side; To be determined

iii. performed by Dr F and/or alternatively he was present during the Biopsy. To be determined

b. made an addendum entry to the Report at around 13:07 stating, 'The solid lesion identified and biopsied is on the lower pole of the left kidney'; To be determined

~~8.~~9. On or around 2 March 2020, you asked the histopathology department to amend the histopathology report for the Biopsy to state, 'Specimen location should be left renal lesion'. Amended pursuant to Rule 17(6) / To be determined

~~9.~~10. You knew that the information you:

a. provided as set out at paragraph ~~7~~8a(i) was untrue because Dr E did not perform the Biopsy; Amended pursuant to Rule 17(6) / To be determined

b. provided as set out at paragraph ~~7~~8a(ii) was untrue because the Biopsy had been taken from the right side; Amended pursuant to Rule 17(6) / To be determined

c. provided as set out at paragraph ~~7~~8a(iii) was untrue because Dr F did not perform the Biopsy and/or was not present during the Biopsy; Amended pursuant to Rule 17(6) / To be determined

d. added as set out at paragraph ~~7~~8b was untrue because the Biopsy had been taken from the right side; **Amended pursuant to Rule 17(6) / To be determined**

e. provided as set out at paragraph ~~8~~9 was untrue because the Biopsy had been taken from the right side. **Amended pursuant to Rule 17(6) / To be determined**

~~10~~.11. Your actions as set out at paragraph:

a. ~~7~~8a(i) were dishonest by reason of paragraph ~~9~~10a;
Amended pursuant to Rule 17(6) / To be determined

b. ~~7~~8a(ii) were dishonest by reason of paragraph ~~9~~10b.
Amended pursuant to Rule 17(6) / To be determined

~~a~~.c. ~~7~~8a(iii) were dishonest by reason of paragraph ~~9~~10c.
Amended pursuant to Rule 17(6) / To be determined

~~b~~.d. ~~7~~8b were dishonest by reason of paragraph ~~9~~10d;
Amended pursuant to Rule 17(6) / To be determined

~~c~~.e. ~~8~~9 were dishonest by reason of paragraph ~~9~~10e.
Amended pursuant to Rule 17(6) / To be determined

The Facts to be Determined

28. In light of Dr Martinez Higueros's response to the Allegation made against her, the Tribunal was required to determine the Allegation in its entirety.

Witness Evidence

29. The Tribunal heard oral evidence and received witness statements on behalf of the GMC from the following witnesses:

- Dr AA, Clinical Director for Medical Specialities at the Hospital (at the time of the events before this Tribunal), and a Consultant Cardiologist, witness statement dated 3 December 2021;
- Mr E, Interventional Radiology Senior Nurse at the Hospital, witness statement dated 30 December 2022;
- Dr F, Consultant Radiologist at the Hospital, witness statement dated 9 December 2021. Dr F also provided a supplementary witness statement, dated 22 March 2022;
- Mr G, Imaging Systems Manager at the Hospital, witness statement dated 14 January 2022;

- Ms BA, Head of Imaging at the Hospital, dated 31 January 2022. Ms C also provided a supplementary witness statement, dated 19 July 2022;
- Ms H, Urology Clinical Nurse Specialist at the Hospital, witness statement dated 19 June 2023;
- Mr J, Prostate Pathway Manager at the Hospital (at the time of the events before this Tribunal, witness statement dated 26 June 2023;
- Dr K, Consultant covering the interventional list at the Hospital (at the time of the events before this Tribunal), witness dated 13 April 2022.
- Dr L, Foundation Year 1 (FY1) doctor in Acute Medicine at the Hospital (at the time of the events before this Tribunal), witness statement dated 9 December 2021;
- Dr N, Consultant in Acute Medicine at the Hospital, witness statement dated 19 January 2022;

30. The Tribunal also received expert reports from Dr M, Consultant Radiologist, on behalf of the GMC. These were dated 20 September 2020, 23 February 2021, 24 November 2022 and 2 June 2023. Dr M also provided oral evidence during the hearing. When the case was reopened after Dr Martinez Higueros provided a fifth statement, Dr M provided a further supplemental report dated 6 July 2023, and gave further oral evidence when recalled to do so.

31. The Tribunal also received witness statements from the following witnesses who were not called to give evidence:

- Dr O, ST3 at the Hospital (at the time of the events before this Tribunal), on behalf of the GMC, dated 7 January 2022;
- Dr P, Consultant Urological Surgeon, and head of the local MDT at the Trust, dated 24 June 2023.
- Ms Q, Senior Staff Nurse at the Hospital (at the time of the events before this Tribunal), undated.

32. Dr Martinez Higueros provided her own witness statements, dated 21 May 2023, 15 June 2023, two subsequent witness statements which were undated, and a fifth witness statement, dated 6 July 2023. She also gave oral evidence at the hearing.

Documentary Evidence

33. The Tribunal had regard to the documentary evidence provided by both parties. This evidence included but was not limited to:

<u>On behalf of the GMC</u>

- Serious Incident Report in respect of Patient A, undated;

- Internal email from Dr F regarding the incident with Patient A, dated 13 December 2019;
- Statement from Dr N for the Trust investigation, regarding the Patient A incident, dated 17 December 2019;
- Various internal email correspondence regarding Patient A, various dates;
- Statement from Dr O for the Trust investigation, regarding the Patient A incident, dated 13 December 2019;
- Statement from Mr E statement for the Trust investigation, regarding the Patient A incident, dated 13 December 2019;
- Serious Incident Report in respect of Patient B, undated;
- Notes of an investigation meeting with Mr E regarding Patient B, which took place on 7 January 2021;
- Notes of a meeting between Dr Martinez Higueros, Dr F and Ms BA, which took place on 28 February 2020;
- Statement of Dr Martinez Higueros regarding Patient B, undated;
- Histopathology report regarding Patient B;
- Various internal email correspondence regarding Patient B, various dates;
- Original biopsy request for Patient B, dated 27 January 2020;
- Screenshot of authorised/finalised RIS report completed by Dr Martinez Higueros, dated 6 February 2020;
- World Health Organisation ('WHO') checklist for Patient B, dated 6 February 2020;
- Report of examinations performed by Dr Martinez Higueros, Various;
- Screenshot from CERNER with the original request for Patient A, dated 11 December 2019;
- Screenshot of an authorised/ finalised RIS report for Patient A, dated 12 December 2019;
- Datix reports of incidents regarding Patient A and Patient B;
- Email from Dr F to Dr K regarding Dr Martinez Higueros supervision, dated 13 September 2019;
- Radiology Rota for week commencing 3 February 2020;
- Note of the incident regarding Patient B from Dr K, dated 28 February 2020;
- Medical records of Patient A;
- Medical records of Patient B;
- Email correspondence chain between Dr P and the GMC;
- Witness statement of Ms Q, undated, for the Hospital investigation, accompanied by email correspondence between the Hospital and the GMC;
- Email correspondence between Dr P and the GMC, dated 14 June – 3 July 2023.

On behalf of Dr Martinez Higueros

- Email correspondence between Dr P and Ms R at the Hospital, regarding information about the serious incident relating to Patient B, dated 29 November 2020;
- Datix Trust investigation form regarding Patient B, dated 27 February 2020;
- Histopathology Report - Renal Biopsy, dated 13 March 2020;
- MDT review decision on 'PACS', dated 31 January 2020;
- Track History of Biopsy Request, undated;
- Logbook of procedures on 06 February 2020;
- Email to Dr Martinez Higueros from the Trust, dated 3 August 2020, which had attached: Redacted patient notes relating to specific procedure; SUI report; Minutes following informal meeting with Dr F and Ms BA; Statement provided by Dr S and Dr K; CM report amendment;
- Email from Dr Martinez Higueros to Dr T, Urology MDT, dated 28 February 2020;
- Patient B's Witness Statement Bundle;
- Email thread between Radiology, Urology and Governance at the Trust, various;
- MRI report for Patient B, dated 15 January 2020;
- Dr Martinez Higueros's CV;

34. The Tribunal noted that there were Character references for Dr Martinez Higueros:

- Dr W, Clinical Lead - Vascular and Interventional Radiology at East Kent & Canterbury Hospital, dated 19 April 2022;
- Dr U, Consultant Radiologist. TRG Imaging, Auckland, New Zealand, dated 28 February 2022;
- Dr V Consultant UroRadiologist at Royal Hallamshire Hospital Sheffield, dated 31 March 2022;
- Dr X Consultant Radiologist at Northampton General Hospital, dated 2 April 2022;
- Mr Y, Retired consultant urologist, and Ms Z Retired consultant anaesthetist, dated 20 April 2022.

LQC Legal Advice

35. In accordance with *Rule 17(2)(j)* of the Rules, the Tribunal is now required to deliberate to make its findings on the facts alleged. In deciding on the facts, there are a number of matters the Tribunal should consider.

36. The Tribunal must bear in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Martinez Higueros does not need to prove anything.

37. The case of *Byrne v GMC [2021] EWHC 2237 (Admin)* confirms that there is only one standard of proof in civil and regulatory cases and that remains that of the balance of probabilities, i.e., whether it is more likely than not that the events occurred as alleged. The Tribunal is reminded that this is a case of dishonesty, which is serious, and so a careful consideration of the evidence will need to take place when deciding if this standard is met. The *probability* of the relevant conduct is a matter which can be taken into account when weighing up and deciding whether the event or conduct occurred; this goes to the quality of evidence.

38. In relation to dishonesty, the Tribunal is directed to apply the test as set out by Lord Hughes at paragraph 74 of *Ivey v Genting Casinos [2017] UKSC 67* which states:

> *"74. When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

39. Therefore, the Tribunal must ascertain (subjectively) the actual state of Dr Martinez Higueros's knowledge or genuinely held belief as to the facts at the material time. The Tribunal should then decide whether this was dishonest by the objective standards of ordinary decent people. If this is not established, then the Allegation would not be proved.

40. The Tribunal is directed that inferences may properly be drawn from the evidence (that is to say common sense conclusions based on the available evidence), as established in the case of *Malhar Soni v GMC [2015] EWHC 364 admin.* The Tribunal must be mindful when drawing inferences, that it has been able to safely exclude as less than probable any other possible explanations given by the Doctor. It should only draw an inference if it can safely exclude other possibilities.

41. The Allegation relates to 2 separate incidents that took place on different dates and relate to different procedures and patients. Whilst the Tribunal is reminded that it should consider each part of the Allegation separately, it is entitled, when deciding on one part of the Allegation to have regard to the evidence relating to another part, as long as it is relevant and admissible. This is known as cross admissibility and was considered by the Court of Appeal in the criminal cases of R v Freeman, R v Crawford [2008] EWCA Crim 1863 *(CLW 08/32/2)* and *(Chopra [2006] EWCA Crim 2133; [2007] 1 Cr App R 16).*

42. In *Freeman,* the Court of Appeal noted firstly that evidence of one count (in this case paragraph) may be admissible in relation to another where the similarity of the evidence is such that it may be probative, because it makes it more likely that the offence was committed. In *Chopra,* the Court of Appeal decided that the court can take into account

evidence from different complainants in support of each other, provided it was satisfied that there was not collusion or contamination. Also, that it is a matter for the court to weigh up the similarities and dissimilarities of the evidence.

43. This approach is subject to the following caveats: first, the Tribunal must be satisfied that it is fair to take that approach, and second, it should be balanced against the Doctor's evidence that she had not made the mistakes as alleged, nor did she act dishonestly after either procedure.

44. The Tribunal should consider carefully all the oral and written evidence adduced and submissions made (it being accepted that submissions are not evidence.) The case of *R (on the application of Dutta) v GMC (2020) EWHC1974 (Admin)* sets out the approach to be taken when considering oral evidence. Oral evidence is the common law gold standard. The Tribunal should note that the incidents date back to 2019 and 2020, and so the passage of time is a factor as memories can fade. The Tribunal should therefore navigate the evidence by looking at contemporaneous material, such as documents, as a starting point, although corroboration of a witness account is not legally necessary. The tribunal must assess oral evidence in the round and not just rely on the demeanour of the witness. A confident witness may give unreliable evidence. A nervous and hesitant witness may give reliable evidence.

45. The Tribunal must judge the doctor's evidence by precisely the same fair standards as apply to any other evidence in the case. If the Tribunal accepts the evidence from a witness - rather than the evidence of the Doctor - it must explain why in its reasoning.

46. The Tribunal should note that a witness statement with a signed statement of truth is also to be treated as if were given as oral evidence. However, there is some hearsay in this case, that is statements and reports from witnesses who heard accounts from others but did not witness incidents themselves. There are also statements from witnesses whose evidence has not been tested. Although this evidence can be considered if relevant, the Tribunal should be aware that it is likely to carry less weight than direct evidence.

47. It should be noted that some of the material shows that DATIX Reports were raised after these two incidents, and the Tribunal is aware that investigations then took place. This Tribunal is directed to consider these as part of the case only and to make its own independent decision.

48. The Tribunal has heard from one expert, Dr M, who has given evidence that is outside the Tribunal's general knowledge. The Tribunal should consider whether the expert has sufficient expertise to express the opinions that he has on the topics that he has. This is a matter of weight for the Tribunal to assess.
Generally, a tribunal does not have to accept expert opinion, but if it decides not to accept it, then it must set out our reasons why that is the case. This is established in the case of *Cohen v GMC (2008) EWHC 581 (admin).*

49. In summary, the Tribunal should have regard to the whole of the evidence and form its own judgement about the witnesses, and which evidence is reliable, and which is not.

50. GMC Counsel has confirmed that a good character direction can be given. There are also some character references that have been drawn to the Tribunal's attention. They can be considered, and the Tribunal can attach such weight on them as is considered appropriate.

51. Therefore, the Tribunal will have in mind that the Doctor is of good character. This means that she has no criminal convictions or cautions or adverse regulatory findings. The Tribunal is reminded therefore that this could mean that a doctor is

(a) more likely to be telling the truth in his or her evidence, and

(b) less likely to have behaved in a way as set out in the Allegation.

52. However, good character of itself does not amount to a defence and its significance should not be over inflated. The primary focus should be on the evidence related to the wrongdoing.

The Tribunal's Analysis of the Evidence and Findings

Patient A

Paragraph 1 of the Allegation

1. On 12 December 2019 you were requested by Dr G to perform a diagnostic left pleural aspiration ('the Aspiration') on Patient A but you performed a therapeutic right sided pleural drainage ('the Drainage').

53. Dr N was a locum consultant in acute medicine at the time of this incident and she made a statement dated 17 December 2021, and gave evidence to the Tribunal.

54. Dr N confirmed that Patient A had been admitted for investigation of a *"progressing left sided pleural effusion"*. She noted that the patient had a history of breast cancer and had already undergone a mastectomy of the left breast, so a malignant pleural effusion was part of a differential diagnosis.

55. Because of this, Dr N made a decision that a diagnostic left pleural tap (meaning "aspiration") was needed under Ultrasound (US) guidance on the ward, to be followed by a CT Chest scan to exclude underlying malignancy.

56. She described that this decision was then changed when Dr O was concerned about performing the tap. She said in her statement that:

> *"On 11/12/19Dr O, locum ST3 SpR confirmed the presence of a left sided pleural effusion with ultrasound, using the US machine of the Acute Medicine department.*
>
> *Dr O didn't feel confident of performing the diagnostic tap as, due to previous mastectomy, the anatomy was altered and the patient was not compliant with positioning. We agreed that it would be safer to seek for radiology help in the IR department."*

57. Dr O made a witness statement, dated 7 January 2022, which was admitted as evidence by the GMC. This statement confirmed that he took the view that the aspiration was better performed with the assistance of Interventional Radiology (IR). He said:

> *"6. As part of my ward duties, I reviewed Patient A with a view to taking a sample of the fluid on Patient [A]'s left lung. This was my first interaction with Patient A. When I assessed Patient A I determined that the procedure would be more safely done within IR…."*

58. Both Dr N and Dr O confirmed that a junior Doctor ("FY1" doctor) was asked to request IR to conduct the procedure. Dr O said in his statement:

> *"7. Dr L, FY1, put a request in the system for Patient A to be taken down to radiology and for the assessment to take place there…"*

59. Dr L was the FY1 doctor in Acute Medicine at the time. She made a statement dated 9 December 2021, and gave oral evidence at the Tribunal. She confirmed that she was present at a ward round on 11 December 2019, when Patient A was examined. She confirmed that the consultant wanted to get a pleural aspirate from Patient A for diagnostic purposes. She confirmed that Dr O asked her to request that the procedure be done by the IR team. She said:

> *"3. The registrar went to look at the patient after the ward round, and as it was going to be quite a complicated procedure, he didn't feel comfortable doing it on the ward, so he asked me to request it in interventional radiology.*

60. Dr L described how this request was made both in her statement and also when she gave her oral evidence. She confirmed that she spoke directly to Dr Martinez Higueros, after being directed to her by the radiology department. She described the meeting with her thus:

> *"4. I went to go and find her, and I found her in a dark room where radiology consultants do reporting. She was sitting in there with a radiology junior. We discussed the procedure and I asked her what we needed. We then looked at the imaging for the patient, which showed a a[sic] left sided pleural effusion on the chest x-ray. I explained that we couldn't do it on the ward and asked her if she was able to do it. She said yes, she could, and told me to book it. The radiographer said it's fine to go ahead, and we'll do it tomorrow. Because Dr Martinez Higueros was the one doing the procedure, she had to agree that it was a possible procedure that she could do and that it was clinically indicated. She hadn't seen the patient before the procedure."*

61. The Tribunal noted that Dr L made it clear that she had spoken to Dr Martinez Higueros about the procedure on 11 December 2019. She had said that the procedure could not be done on the ward, and that Dr Martinez Higueros confirmed that she would do it. This was unchallenged evidence when Dr L gave live evidence during this hearing.

62. Dr L then described what happened the following day, 12 December 2019, when the procedure was due to take place. She said:

> *"5. I came into work the next morning on 12 December 2019 to check that they were still doing the procedure, and I went down to the interventional radiology room at 8:30am. I didn't speak to Dr Martinez Higueros at all that morning before the*

procedure, I only spoke to the radiographers. On the board, they had written: "left-sided plural(sic) drain." I said to the chief radiographer, it's not a plural(sic) drain, it's just a plural(sic) aspirate, and she changed it on the board to say "left-sided plural(sic) aspirate". I then went back up to the ward and carried on with my job."

63. The Tribunal heard evidence that there was a new Trust Electronic Patient Record computer system called CERNER which had been installed at the hospital on 4 November 2019. It had only been in place for a little over a month at the time of this incident. It heard that there had been a number of initial issues with the system, one being that the drop-down menu was difficult to navigate. Dr L could not find the correct drop down box to indicate that an aspiration was required as a procedure, because this was not a routine request, as this procedure was usually carried out on the ward.

64. The Tribunal noted that the CERNER report was therefore inaccurate and could have caused confusion.

65. The CERNER request submitted by Dr L shows that it was made and electronically signed by *[Dr L] on 11/Dec/2019 at 13:58 GMT*. Its header then stated:

"Radiology Department

US Guided drainage thorax (RAD) (US Guided drainage chest (RAD))"

66. The Tribunal noted that a drainage was requested on this header, despite an aspiration being what was required. The Tribunal also noted that, further down the CERNER request under a section headed *"clinical details"* Dr L had entered:

"L sided pleural effusion, abnormal anatomy unable to blind aspirate".

67. Dr N told the Tribunal that, as there were issues with CERNER, there was a work around that when a procedure was added to the system, someone would be sent to speak to the doctor undertaking the procedure to speak to them directly. She said that this is why Dr L was sent to speak to Dr Martinez Higueros to confirm what was required.

68. In her initial response to Dr N and Dr F, Dr Martinez Higueros claimed that Dr L had requested her to perform the drain. In her later responses, she said that Dr L had not spoken to her before the procedure.

69. The Tribunal, however, noted the oral evidence from Dr L in which she said that she had a discussion about the nature and location of the required procedure with Dr Martinez Higueros on 11 December 2019. This evidence was unchallenged.

70. In her oral evidence to the Tribunal, Dr Martinez Higueros accepted that she had a discussion with Dr L but characterised it as an informal conversation.

71. Dr Martinez Higueros's accounts relating to the discussion with Dr L were contradictory and Dr L's account was clear and not cross examined.

72. Both in her witness statements and during her oral evidence, Dr Martinez Higueros said that as there was fluid in both lungs, she performed a right sided pleural drainage as a therapeutic procedure as it was, in her view, best for the patient.

73. The Tribunal was therefore satisfied that factually Dr Martinez Higueros was asked by Dr L to perform a diagnostic left pleural aspiration on Patient A but instead performed a therapeutic right sided pleural drainage.

74. The Tribunal therefore found Paragraph 1 of the Allegation **proved.**

Paragraphs 2a, b and c of the Allegation

> 2. You did not:
>
> a. obtain adequate clinical information to determine the intended purpose for the Aspiration, before undertaking the Drainage;
>
> b. discuss the decision to change the procedure with the referring clinicians or another interventional radiology colleague before performing the Drainage;
>
> c. perform the Aspiration as requested by Dr G;

Paragraph 2a

75. Dr Martinez Higueros confirmed in her oral evidence that she knew that the request was for a left sided pleural aspiration. She confirmed also that she took a personal clinical decision to perform a therapeutic right sided pleural drainage, as she thought that it was in the best interests of Patient A. She said that she made this decision for therapeutic reasons to relieve the patient's symptoms. She said that had she not conducted this procedure, the patient would have been returned to the ward without any intervention, with a wait for another appointment.

76. The Tribunal had regard to the second expert report of Dr M, dated 23 February 2021. It was his opinion, having considered the evidence, that Dr Martinez Higueros knew that the procedure requested was for a left pleural aspiration. The Tribunal has also found that, notwithstanding the confusion from the CERNER request, Dr Martinez Higueros knew what had been required because Dr L had spoken directly to her.

77. Dr M confirmed that it was unclear from the evidence whether Dr Martinez Higueros had been provided with the clinical notes for Patient A on 12 December 2019. He noted therefore that it was difficult to know whether Dr Martinez Higueros understood why the procedure had been requested, i.e., that it had been requested for diagnostic, rather than therapeutic reasons.

78. Dr M opined that either Dr Martinez Higueros had received the notes but did not understand the clinical reason for the request or had not received the notes and did not understand why she was carrying out the procedure. Had she understood, then she would not have made the decision to carry out the right sided drainage. Dr M said that it was wholly inappropriate of Dr Martinez Higueros to insert a right pleural drain without understanding the clinical reasons for the original request.

79. The Tribunal accepted and relied upon the expert opinion of Dr M.

80. The Tribunal therefore found Paragraph 2a of the Allegation **proved.**

Paragraph 2b

81. Dr Martinez Higueros's confirmed in her evidence that she made a personal clinical decision to carry out a right sided drainage, despite the request being for a left sided aspiration. She gave evidence that she spoke to the patient about this, and the patient consented to it as recorded in the consent form.

82. Dr Martinez Higueros accepted that she did not discuss the decision to change the procedure with the referring clinicians or another interventional radiology colleague. She said that she had made attempts to do so.

83. Dr M stated that a decision of this nature should have been discussed with the clinicians, or other IR colleagues. In his oral evidence, and in response to questions, he stated that decisions to change a procedure without such discussions with the referring clinicians should only be made in an emergency, or mid procedure. He said that *"You would not proceed with the request unless this was an absolutely emergency, which this was not, and you would not proceed unless you had spoken to the clinical team."*

84. The Tribunal therefore found Paragraph 2b of the Allegation **proved.**

Paragraph 2c

85. In respect of paragraph 2c, for the same reasons as set out in relation to Paragraph 1 of the Allegation, the Tribunal found that Dr Martinez Higueros did not perform the aspiration as requested by Dr L.

86. The Tribunal therefore found Paragraph 2c of the Allegation **proved.**

Paragraph 3a of the Allegation

> 3. Following the Drainage, you failed to:
>
> a. update your colleagues to explain your decision to carry out the Drainage;

87. Dr N stated, in her statement to the Trust that she found out that a drainage had been carried out, after the procedure had taken place, when she received a telephone call from Dr F She said in her trust statement:

> *"On 12/12/19 I was on call and while post-taking a patient, I received a telephone call by Dr F, Service Lead in Radiology Department at 17:21, asking me information regarding [Patient A] as she was reviewing the CT Chest images demonstrating a RIGHT sided chest drain, while the clinical details were "worsening L pleural effusion.? Malignancy".*

88. In her witness statement, dated 9 December 2021, Dr F explained that a member of the radiology team had reported the difference between the request and the procedure that had taken place, after having looked at the images, when they noticed that a right sided drain was in place. She said:

> *"4. On 12 December 2019, there was an incident where Dr Martinez Higueros carried out an ultrasound guided drainage of effusion, and she drained the opposite side that was on the request form and performed a drain insertion versus an aspiration. In other words she performed the wrong procedure and on the wrong*

side... I remember it was a patient in cardiac failure. I think her reasoning behind this was that there were bilateral effusions, but she didn't have any images saved as part of her procedure, and the team were very confused as to why she had done the side she had done. I spoke to the clinical team about it at the time. One of my radiology team had reported some imaging, and they couldn't understand why there was a right-sided drain in, when the request was for a left."

89. Dr F went on to describe having to find Dr Martinez Higueros to find out what had happened, and then informing Dr N. She said:

"I immediately went to find Dr Martinez Higueros to ask her why. She said to me, because there were effusions on both sides, she made the decision to drain the right. I asked her to go and check on the patient, because it seemed very strange that the team had requested one side, and she did the other. She didn't go and see the patient. I contacted the consultant looking after the patient, and she came to the department to speak to me with her registrar, and she wasn't happy at all, because she had requested the other side, and had requested an aspiration, but Dr Martinez Higueros had carried out a drain. It was completely not what they had requested. They wanted an aspiration to be done to look for malignancy. The patient was not symptomatic with heart failure so there was no clinical requirement for a drain in that respect, so the consultant was unhappy. The team requested as aspiration to look for malignancy as the patient previously had left sided breast cancer hence the request for the left sided aspiration."

90. When Dr N was aware of the situation, it was her evidence that she organised a ward meeting so that they could find out what had happened. In her statement to the Trust, Dr N said that the ward meeting took place several hours after the procedure. She said that during that meeting, Dr F asked Dr Martinez Higueros for her rationale as to why she did the drainage, when the medical team had requested diagnostic aspiration; and why she decided to put it in the opposite side. She said that Dr Martinez Higueros claimed that Dr L had requested the drain and that the medical team had signed the consent form with the patient.

91. The consent form was brought to the meeting, and it was confirmed that it was Dr Martinez Higueros that had taken the consent of the patient.

92. In her witness statement, Dr L recounted what happened after the procedure. She explained:

"8. Dr Martinez Higueros then came up to the ward along with the head of the radiology department, and all of the AAU doctors. Everyone was gathering around the patient trying to find out what had happened. At some point Dr Higueros re-ultra sounded the patient to display that there wasn't a pleural effusion on the left, but another doctor disputed this. I think the patient had some cognitive deficit so wasn't able to give full account, but had had no complications, and she was clinically well. There were discussions mainly between my consultant, and Dr Martinez Higueros. I was there for some of them, and not there for some of them. My consultant said to me, this is a serious incident, and she was going to deal with it as senior doctor responsible for the patient, rather than me having conversations.

…

10. I carried on with my other jobs on the ward, and when the seniors came back up, they said to me, Dr Martinez Higueros has tried to blame you for this, and she said that you agreed to the procedure being done on the other side…"

93. In her oral evidence, Dr Martinez Higueros said that it was under her own instigation that she went to the ward to update her colleagues on why she had changed the procedure from the left sided aspiration to a right sided drainage.

94. The Tribunal had regard to the first Radiology Information System ('RIS') computer update made by Dr Martinez Higueros at 15:41 on 12 December 2019, in which she wrote:

"L sided pleural effusion, abnormal anatomy unable to blind aspirate"

95. The Tribunal had regard to the expert evidence of Dr M. In his second expert report, he described the chronology as he had understood from the documentary evidence:

"When the referring clinicians were made aware of the unrequested right sided drainage catheter they asked for a meeting on the ward which took place around 7pm on the 12th December 2019. Dr Martinez Higueros was accompanied to the ward by a radiology colleague. She had an opportunity at that meeting to explain her actions and apologise for the mistake. Again she doesn't appear to have fully engaged with the meeting, performing another ultrasound on during some part of it. She stated that the drain had been placed because that what was requested on CERNER. The evidence suggests that this explanation was disingenuous. She also failed to explain why it had been inserted into the right effusion rather than the left. She appears to have refused to answer this question. In short the evidence suggests she was dishonest."

96. The Tribunal considered the differing accounts carefully. It was satisfied on the balance of probabilities that Dr Martinez Higueros did not update her colleagues for several hours after the procedure. It was satisfied that the RIS computer entry was a "lift" from the CERNER request, and the Tribunal did not consider that this provided Dr Martinez Higueros's colleagues with a meaningful update or explanation.

97. The Tribunal was satisfied that the change of procedure came to light when a member of the IR department had alerted Dr F that the left side aspiration requested had not been done, and that instead a right sided drain had been inserted.

98. The Tribunal accepted the evidence from Dr F and Dr N that she (Dr N) was alerted to the fact that a right sided drain had been inserted, when Dr F contacted her several hours after the procedure.

99. The Tribunal did not accept Dr Martinez Higueros's assertion that it was her who instigated the discussion or the meeting. Evidence from Dr F's showed that Dr Martinez Higueros was told to attend the ward by her. The Tribunal noted that at this point, Dr Martinez Higueros had been working within the hospital for several hours after undertaking the drainage and had not updated her colleagues.

100. The Tribunal also noted that when Dr Martinez Higueros did update her colleagues during the ward meeting, the information she provided was inaccurate and she tried to blame Dr L saying that she (Dr L) had requested a drainage.

101. The Tribunal was therefore satisfied that Dr Martinez Higueros had failed to update her colleagues to explain her decision to carry out the drainage.

102. The Tribunal therefore found Paragraph 3a of the Allegation **proved.**

Paragraph 3b of the Allegation

> 3. Following the Drainage, you failed to:
>
> b. apologise to Patient A for performing the Drainage rather than the Aspiration, during the ward meeting at around 18:00.

103. Dr Martinez Higueros accepted that she did not apologise to Patient A.

104. Dr Martinez Higueros gave evidence that she made a clinical decision to conduct the right sided drainage, and that she had discussed the matter with the patient before the procedure. She confirmed that she had taken the consent of the patient who was content with the proposed course of action.

105. Dr Martinez Higueros said that the drainage was for therapeutic purposes and there was no need for her to apologise because she made a clinical decision to benefit the patient, and that had been explained to her at the time.

106. The Tribunal heard evidence from Dr N that other members of the medical team went to apologise to Patient A because of the duty of candour. They felt the need to explain that the wrong procedure had been carried out and that an apology was needed.

107. In his oral evidence, Dr M said that if there is a change in a procedure and the doctor makes a mistake, or undertakes a procedure without having had a consultation, the doctor is under a duty to tell the patient. In his second report, Dr M said:

> *" She had an opportunity at that meeting to explain her actions and apologise for the mistake."*

108. The Tribunal was satisfied that Dr Martinez Higueros did not apologise to Patient A. She accepted that she did not do so, but said that was because no mistake or wrongdoing had taken place. However, the Tribunal determined that the wrong procedure was carried out and so Dr Martinez Higueros was under a duty of candour and should have apologised to Patient A.

109. The Tribunal therefore found Paragraph 3b of the Allegation **proved.**

Paragraph 4 of the Allegation

> 4. At around 19:28 on 12 December 2019, you added an addendum to the Radiology Information System ('RIS') operative report stating 'unable to perform left side drain insertion, as requested. Decision made on right sided drain insertion. Medical team contacted' ('the Amendment').

110. Mr G, the Imaging Systems Manager at the Hospital, made a witness statement dated 14 January 2022. He confirmed that the system in the hospital was that clinicians updated colleagues by entering information onto the RIS computer system, after conducting procedures. Entries should be made as soon as possible. Partially completed entries can be left open for the doctor to complete later but cannot be seen by other practitioners who access that particular record. Once saved, entries are available for others to see. They cannot be changed or edited, but an addendum (sometimes termed as an amendment) could be added later.

111. The first entry on the RIS operative system was made by Dr Martinez Higueros at 15:41 on 12 December 2019. She wrote:

> *"L sided pleural effusion, abnormal anatomy unable to blind aspirate"*

This was saved on the RIS system. Dr Martinez Higueros gave evidence that this was not her final report and that she intended to submit an addendum with more detail later. She said that it was important to save this entry, as opposed to simply leaving it open, so that other practitioners could see the information. This initial entry was made fairly soon after the procedure and did not describe that a right sided drainage was performed, rather than a left sided aspiration, nor the reasons for it.

112. The addendum on the RIS system made by Dr Martinez Higueros at 19:28 read as follows:

> *"Additional Section, Added: 12/12/2019 19:28 Authorised by: Dr Claudia MARTINEZ*
> *Transcribed by: Dr Claudia MARTINEZ Author: Dr Claudia MARTINEZ*
>
> *Chelsea and Westminster Hospital NHS Foundation Trust*
>
> *Examination Date and Time: 12/12/2019 19:28*
>
> *…*
>
> *12/12/2019 Thorax drainage US guided*
>
> *Procedure:*
> *Informed consent type I. WHO safety check list completed. Sterile technique. Under local anesthetic lidocaine 1%. US scan showed bilateral pleural effusion of significant size. Patient of big IBM with very difficult mobility unable to perform left side drain insertion, as requested. Decision made on right sided drain insertion. Medical team contacted…"*

113. It was not disputed that Dr Martinez Higueros entered this addendum to the RIS report, and that this entry was after the ward meeting had taken place. Dr Martinez Higueros explained that she added it when she had the opportunity to do so. She said that it was not always possible to add contemporaneous notes when the unit was busy, and that it was usual practice to add an addendum at the end of the shift, or as soon as possible.

114. The Tribunal was satisfied that Dr Martinez Higueros did add the addendum to the RIS report as set out above. The Tribunal considered her explanation for saving the entry made at 15:41 instead of leaving it open pending her full update to be implausible. Whilst the Tribunal accepted the need for detailed information to be available, it found that the entry made at 15:41 lacked detail, was inaccurate and would have been of little use to the referring clinicians or other practitioners.

115. The Tribunal therefore found Paragraph 4 of the Allegation **proved.**

Paragraph 5 of the Allegation

> 5. When you made the Amendment you knew that you had not contacted the medical team to discuss your decision to perform the Drainage.

116. This Paragraph did not make clear whether it was being alleged that the contact that Dr Martinez Higueros was implying had taken place was supposed to have been before the procedure took place. The Tribunal therefore considered what contact, if any, had taken place before the procedure and also after the procedure but before the addendum entry.

117. The Tribunal noted that none of the medical team who provided evidence during this hearing said that they had been contacted by Dr Martinez Higueros before 17:28, to discuss her decision to perform the drainage. Dr N stated that no one reported that efforts had been made to contact the ward, and that there were various methods by which the clinical team could have been contacted.

118. Dr Martinez Higueros told the Tribunal that she had made attempts to contact the medical team and that she had requested telephone records from within the hospital that had not been forthcoming.

119. Dr Martinez Higueros said that when she wrote *"medical team contacted",* she meant that she had made efforts to contact them before the procedure.

120. The Tribunal noted that the ward meeting had taken place after the procedure and before the addendum. However, the Tribunal determined that this meeting was not instigated by Dr Martinez Higueros, as she claimed, and she did not provide a full and accurate account of her decision to do the drainage at that meeting.

121. Both Dr F and the expert, Dr M, were asked when giving their evidence, what colleagues would understand the words *"medical team contacted"* to mean. They both said that it would mean that actual contact had been made pre procedure. Other sentences such as *"attempted to contact the medical team"* or *"left messages for the medical team"* would have been written otherwise.

122. The Tribunal had regard to the ordinarily plain English meaning of the word 'contacted', and how it would be understood.

123. The Tribunal was mindful that English was Dr Martinez Higueros's second language. However, she had conducted a large part of the Tribunal hearing unrepresented and was fluent in English. Ms BA gave oral evidence that she spoke to Dr Martinez Higueros regularly and had never noticed an issue with her command of the English language.

124. The Tribunal therefore found Paragraph 5 of the Allegation **proved.**

Paragraph 6 of the Allegation

6. Your actions at Paragraph 4 were dishonest by reason of Paragraph 5.

125. When determining dishonesty, the Tribunal bore in mind the principles set out in the case of *Ivey*. It first considered, subjectively, the actual state of Dr Martinez Higueros's knowledge or belief as to the facts at that relevant time.

126. Dr Martinez Higueros wrote her addendum to the RIS report approximately six hours after the drainage procedure, and after the ward meeting with the medical team during which the matters of concern had been raised with her.

127. It is Dr Martinez Higueros's case that she tried to contact the clinical team and that is what she meant by "*medical team contacted"*. She also made the point that as the saved entries cannot be edited or amended then she was being transparent by adding an addendum when she found the time to do so.

128. As stated at Paragraph 121 above, both Dr F and the expert, Dr M, were asked what colleagues would understand *"medical team contacted"* to mean. They both said that it would mean that actual contact had been made pre procedure. Other sentences would have been written if attempts, but not actual contact, had been made.

129. Dr Martinez Higueros gave varying accounts for her decision to perform a drainage which were at odds with one another and included that; she had made a clinical decision for therapeutic purposes following a meaningful discussion with Patient A; that Dr L had told her to do the drainage; and that due to difficult mobility, she was unable to perform left side drain insertion as requested and made the decision to perform a right sided drain insertion, as per the addendum.

130. Again, the Tribunal noted that English was Dr Martinez Higueros's second language but was however satisfied that there was no concern with Dr Martinez Higueros's knowledge or understanding of the English language.

131. The Tribunal was satisfied that Dr Martinez Higueros knew subjectively that when she made the addendum to the RIS report stating that she had contacted the medical team, she had not contacted the medical team. The Tribunal determined that Dr Martinez Higueros made that note in an attempt to cover her tracks, as she knew that she had carried out the wrong procedure.

132. The Tribunal then considered the second limb of *Ivey.* It concluded that at an ordinary decent member of the public, fully informed of all the details of this case would consider that Dr Martinez Higueros's conduct as set out above would amount to dishonest behaviour.

133. The Tribunal was mindful that Dr Martinez Higueros was of good character but nevertheless felt that on balance, her actions were dishonest.

134. The Tribunal therefore found Paragraph 6 of the Allegation **proved.**

Patient B

Paragraph 7 of the Allegation

7. On 6 February 2020 you carried out a biopsy on Patient B's right kidney ('the Biopsy'), on which you entered a RIS report ('the Report') stating 'US confirmed solid component of the upper right renal pole lesion'.

135. On 7 January 2020, Patient B underwent a urogram CT scan which showed bilateral indeterminate renal cysts and it was recommended the patient have an MRI to determine the nature of these cysts. The MRI scan took place on the 15 January 2020 and was reported by Dr Martinez Higueros as showing a Bosniak 3 right upper renal cyst and a solid left lower pole lesion. Patient B then attended the urology outpatient clinic on 27 January 2020 where he was informed of the MRI results.

136. On the 29 January 2020, Patient B was listed for a urology multi-disciplinary team (MDT) discussion. The radiologists attending the MDT reviewed the CT and MRI scans and agreed that the left renal lesion was suspicious for malignancy and recommended biopsy. The outcome of this MDT was documented that the patient was waiting for a *"LEFT renal biopsy"* to take place in the Interventional Radiology (IR) Department.

137. The Tribunal was satisfied that the procedure that was requested and expected was for a left renal biopsy. In her oral evidence, Dr Martinez Higueros accepted that a left renal biopsy was requested, and she confirmed that she carried out that request.

138. The Tribunal therefore considered the evidence carefully to determine which kidney was biopsied. It took into account a number of contemporaneous documents.

139. The procedure was carried out on the 6 February 2020. Before the patient was taken into the operating room, he and Dr Martinez Higueros signed a consent form, to confirm that he agreed to the procedure taking place. The consent form states that the name of the proposed procedure or course of treatment as:

"US Guided Right Renal Biopsy".

140. Dr Martinez Higueros said that the consent form was signed by the patient before the procedure but it did not state on the consent form which kidney would be biopsied and in that respect was left blank. She said that she wrote *"right biopsy"* on the form after the procedure had taken place and that this was an error on her part.

141. Shortly before, during and after any procedure is carried out, a World Health Organisation (WHO) checklist, should be completed. There are sections on the checklist to be filled out at each stage. The column filled out by a nurse straight after the procedure on 6 February 2020, states:

"Kidney Biopsy RIGHT".

142. The Tribunal had regard to the RIS computer entry completed by Dr Martinez Higueros, dated 6 February 2020 in which it stated;

"US confirmed solid component of the upper right renal pole lesion"

143. The Radiology Care Plan, dated 6 February 2020, records the *puncture site* as the *"right side"*

144. The Discharge Summary, dated 6 February 2020, states:

"Discharge Summary
Clinical Summary: Patient attended AEC for USS guided kidney biopsy right
…
Dressing dry and intact on the punctured site"

145. The Tribunal considered that had the dressing been on the left side, the notes would have made that clear.

146. The Tribunal also noted the evidence given by witnesses.

147. Nurse Mr E was interviewed during the Trust Investigation into the incident. The notes of that investigation meeting, dated 7 January 2021, state:

*"**Nurse Mr E** - Before we do a procedure we do the WHO checklist with the doctor. We prepared the patient and before the procedure was completed the signing in was done with Dr Martinez and after the procedure we call it out again. At the end of procedure they called out 'right' and I wrote it down and Dr Martinez signed it.*

***Investigator** - There was a box that you ticked that marked the side. Did you observed Dr Martinez doing the preliminary scan selecting the appropriate site. On the sign out part of the form, the procedure is stated as kidney procedure right; is this in your handwriting?*

***Nurse Mr E** - Yes, that is my handwriting and the procedure would have been completed on the right. Before we have it signed off we show everything to the doctor and then they sign it off."*

148. Nurse Mr E gave oral evidence and confirmed that he was present in the radiology department and that he noted that the patient was lying on the left, suggesting that a right sided procedure was carried out.

149. Nurse H was a Urology Clinical Nurse Specialist at the Hospital, and she made a witness statement dated 19 June 2023 and gave oral evidence at the Tribunal. She had conducted a follow up meeting with Patient B who told her that the biopsy had been on the right kidney and that his dressing was located on that side.

150. Dr Martinez Higueros had a meeting on 28 February 2020 with Dr F and Ms BA ('the meeting'). Dr F and Ms BA state that they were both present, but Dr Martinez Higueros does not accept this. She said that it the meeting was with her and Dr F only. During that meeting, Dr Martinez Higueros at first stated that the biopsy was on the right:

[Ms BA]	*"I'm just interested to know if you understand why we are asking you to look at this. Can you look at your report from the biopsy again and see if you can spot why this was raised as a complaint"*
[Dr Martinez-Higueros]	*"well yea, the incongress between the left and the right. But it was the right."*

[Ms BA]	*"You definitely did the right?"*
[Dr Martinez-Higueros]	*"Yes"*
[Dr F]	*"but they requested the left?!"*
[Dr Martinez-Higueros]	*looked at the images again and her report again*
[Dr F]	*"they requested the left [Dr Martinez-Higueros]. Did you read the MDT entry? What did it say. Can you read it?"*
[Dr F]	*"please read it out"*
[Dr Martinez-Higueros]	*read "right sided renal lesion…" but did not complete reading the MDT comments*
[Dr F]	*"what does it say [Dr Martinez-Higueros]?"*
[Dr Martinez-Higueros]	*"left side"*
[Dr F]	*"so why did you do the right side?"*
[Dr Martinez-Higueros]	*"no it was not the right, sorry, no! Because we got several cases in a row. It was from the proper left renal lesion and it was not Dr K, it was Dr S, I remember 'cause there was another case, similar case on the right side the following days I think, I don't remember but I can find the case for you"*

151. Mr G provided a report listing the procedures that had been carried out by the IR department around the time of Patient B's procedure, who had performed them and the type of procedure they were. The report shows that Dr Martinez Higueros did not undertake a similar right sided procedure around that time and consequently undermines her claim that she had a similar case on the right side in the following days.

152. It was Dr Martinez Higueros's case that the biopsy was carried out on the left kidney and that the word '*Right'* in the documentation was a mistake or a typographical error. In her first witness statement, dated 21 May 2023, she stated that:

> *"19. On the 6 February 2020 I carried out a biopsy on Patient B's left kidney. I am very clear that it was the left kidney and not the right. I accept that I inadvertently inaccurately recorded on the RIS report that "US confirmed solid component of the upper right renal pole lesion". Clearly this was a recording error on my part."*

153. The Tribunal was satisfied that there were a number of documents that recorded and witnesses who gave evidence showing that showed that the biopsy was conducted on the right kidney. Against this evidence, the Tribunal considered that Dr Martinez Higueros's explanation that references to the right side in documents and the RIS record, and her

suggestion that the patient consented by signing an incomplete consent form to be implausible.

154. It was therefore satisfied that Dr Martinez Higueros had carried out a biopsy on Patient B's right kidney on 6 February 2020 and entered a RIS report stating: *"US confirmed solid component of the upper right renal pole lesion"*.

155. The Tribunal therefore found paragraph 7 of the Allegation **proved.**

Paragraphs 8ai, ii and iii of the Allegation

> 8. On 28 February 2020 you:
>
> a. were interviewed by Dr C and Ms D at around 09:45 and stated that the Biopsy was:
>
> i. performed by Dr E;
>
> ii. taken from the left side;
>
> iii. performed by Dr F and/or alternatively he was present during the Biopsy

156. Dr F (Dr C) conducted a meeting with Dr Martinez Higueros on 28 February 2020, when she interviewed her about the procedure on Patient B. This was 3 weeks after the procedure and Dr F had heard that the wrong kidney might have been biopsied. Dr F arranged the meeting, and she confirmed in her statement and in her oral evidence that Ms BA (Ms D) was also present.

157. Ms BA stated in her statement and oral evidence that she was present too, and that she took notes. Both Ms BA and Dr F gave oral and written evidence that they were both present and that the notes were an accurate reflection of the conversation that took place.

158. In her oral and written evidence, Dr Martinez Higueros disputed that Ms BA was in attendance at the meeting on 28 February 2020, and was adamant that the meeting took place between her and Dr F only.

159. The Tribunal considered that were this assertion to be correct Ms BA and Dr F must have lied about both being present and fabricated the notes of the meeting since they are both referred to in the text, and colluded in order to do so. Whilst the Tribunal noted there was some inconsistency as to where the meeting took place and noted that the handwritten notes had apparently been destroyed, it was of the view that there was no evidence to suggest any collusion. It therefore accepted that both Dr F and Ms BA were present and conducted the meeting with Dr Martinez Higueros on 28 February 2020.

160. The Tribunal noted the concerns raised by Dr M with regard to the manner in which the meeting was conducted. He noted that Dr Martinez Higueros was not given the opportunity to have anyone present with her, it was pressurised, and she was asked to produce a written statement within the hour. The Tribunal noted however that Dr M was not an expert in conducting such investigatory meetings.

161. Dr Martinez Higueros was asked about the meeting when she gave her evidence at the Tribunal. She confirmed that she had not felt coerced, and that this was one of a number

of meetings that had been conducted in a similar vein during her time at the Trust. The Tribunal considered this meeting carefully and thought it very unfortunate that a copy of the notes taken of the meeting were not provided to Dr Martinez Higueros for her approval at the time. The Tribunal also considered that Dr F had only just discovered the issue of Patient B's biopsy and, as the senior person responsible, was entitled to make urgent enquiries to establish the basic facts. Speaking to Dr Martinez Higueros as soon as possible was an obvious first step in establishing those facts.

Paragraph 8a(i)

162. In relation to the role of Dr K, in the notes of the meeting of the 28 February, it is recorded:

[Dr Martinez-Higueros]	*"looked at her report and the CT images before saying "oh yea, yea, it was Dr. K with me."*
[Ms BA]	*"So he was in the room with you?"*
[Dr Martinez-Higueros]	*"Yes he was. He did the procedure actually. I did the report because that is the normal way we work"*
[Dr F]	*"but his name isn't even on the report"*
[Dr Martinez-Higueros]	*"Yea, that was my mistake I recognise this, but the procedure was with Dr K"*

Paragraphs 8a(ii)

163. In relation to the side that the kidney biopsy took place, in the notes of the meeting of the 28 February, it is recorded:

[Ms BA]	*"I'm just interested to know if you understand why we are asking you to look at this. Can you look at your report from the biopsy again and see if you can spot why this was raised as a complaint"*
[Dr Martinez-Higueros]	*"well yea, the incongress between the left and the right. But it was the right."*
[Ms BA]	*"You definitely did the right?"*
[Dr Martinez-Higueros]	*"Yes"*
[Dr F]	*"but they requested the left?!"*
[Dr Martinez-Higueros]	*looked at the images again and her report again*
[Dr F]	*"they requested the left [Dr Martinez-Higueros]. Did you read the MDT entry? What did it say. Can you read it?"*
[Dr F]	*"please read it out"*

[Dr Martinez-Higueros] *read "right sided renal lesion…" but did not complete reading the MDT comments*

[Dr F] *"what does it say [Dr Martinez-Higueros]?"*

[Dr Martinez-Higueros] *"left side"*

[Dr F] *"so why did you do the right side?"*

[Dr Martinez-Higueros] *"no it was not the right, sorry, no! Because we got several cases in a row. It was from the proper left renal lesion….*

Paragraph 8 a(iii)

164. In relation to the side to the role of presence of Dr F, in the notes of the meeting of the 28 February, it is recorded:

"….and it was not Dr K, it was Dr S, I remember 'cause there was another case, similar case on the right side the following days I think, I don't remember but I can find the case for you"

165. The Tribunal was satisfied that Dr F and Ms BA had both been present at this meeting. The notes of the meeting, which it has accepted as accurate and credible, demonstrate that Dr Martinez Higueros did state that the biopsy was performed by Dr E, was taken from the left side; and was performed by Dr S (Dr F) and/or alternatively he was present during the biopsy.

166. The Tribunal therefore found paragraphs 8ai, ii and iii of the Allegation **proved.**

Paragraph 8b of the Allegation

8. On 28 February 2020 you:

b. made an addendum entry to the Report at around 13:07 stating, 'The solid lesion identified and biopsied is on the lower pole of the left kidney';

167. The Tribunal had regard to the Addendum RIS report on 28 February 2020 at 13:07 which states:

"Additional Section, Added: 28/02/ 2020 13:07 Authorised by: Or Claudia MARTINEZ Transcribed by: Dr Claudia MARTINEZ

Chelsea and Westminster Hospital NHS Foundation Trust

---- ------ CHELSEA ANO WESTMINSTER HOSPITAL------- --

Patient Name: Patient B

…

Amendment:

The solid lesion identified and biopsied is on the lower pole of the left kidney."

168. Dr Martinez Higueros accepted that she made this entry, stating that she made it in order to explain her earlier error in the first entry.

169. The Tribunal therefore found Paragraph 8b of the Allegation **proved.**

Paragraph 9 of the Allegation

9. On or around 2 March 2020, you asked the histopathology department to amend the histopathology report for the Biopsy to state, 'Specimen location should be left renal lesion'.

170. The Tribunal had regard to the histopathology report for Patient B which indicated that a correction was requested by Dr Martinez Higueros on 2 March 2020:

"Addendum Diagnosis

A CORRECTION IN THE GIVEN CLINICAL INFORMATION RECEIVED FROM Dr. Claudia Martinez, from IR Chelsea and Westminster Hospital on 2/3/2020

SPECIMEN LOCATION SHOULD BE LEFT RENAL LESION"

171. Dr Martinez Higueros accepted that she sent this request for this addendum/correction to be made to histopathology. She explained that it was to rectify her earlier error, when she said that the right kidney had been biopsied.

172. The Tribunal therefore found paragraph 9 of the Allegation **proved.**

Paragraphs 10a, b, c, d and e of the Allegation

10. You knew that the information you:

a. provided as set out at paragraph 8a(i) was untrue because Dr E did not perform the Biopsy;

b. provided as set out at paragraph 8a(ii) was untrue because the Biopsy had been taken from the right side;

c. provided as set out at paragraph 8a(iii) was untrue because Dr F did not perform the Biopsy and/or was not present during the Biopsy;

d. added as set out at paragraph 8b was untrue because the Biopsy had been taken from the right side;

e. provided as set out at paragraph 9 was untrue because the Biopsy had been taken from the right side.

173. Paragraphs 10a-c of the Allegation as set out above refer to responses given by Dr Martinez Higuero during the meeting with Dr F and Ms BA.

174. The Tribunal considered the possibility that in giving her responses, Dr Martinez Higueros was mistaken or confused having been called into the meeting at short notice. However, having regard to the record of the meeting, it is clear that Dr F and Ms BA explained the circumstances and gave Dr Martinez Higueros access to online records before she offered her responses.

Paragraph 10a

175. The Tribunal noted that Dr K (Dr E) had been nominated to supervise Dr Martinez Higueros. This had been agreed when she had first arrived at the hospital, and the situation was being monitored. In his oral evidence, Dr K said that he was not directly supervising Dr Martinez Higueros for every routine procedure but that he indirectly supervised her. This meant that he was in the department when she was performing procedures, and that he gave Dr Martinez Higueros pre-operative advice. Dr F gave evidence that she was expecting more direct supervision by Dr K and that he should have been present during the procedure, supervising Dr Martinez Higueros.

176. Dr K said that in relation to Patient B, that he had given some preoperative advice, but was not in the room when the procedure was carried out. He confirmed that he did not perform the biopsy.

177. The Tribunal noted that Dr K's name was not on the WHO checklist for the procedure.

178. In her later statements and in oral evidence, Dr Martinez Higueros accepted that she performed the biopsy.

179. During the meeting, Dr Martinez Higueros asserted twice that Dr K had performed the biopsy. The Tribunal was satisfied that, having had the context of the meeting explained to her and been given the opportunity to read the RIS records, Dr Martinez Higueros was not mistaken as a consequence of being called into the meeting at short notice. It determined that she must have known that, at the time of giving her responses to Dr F and Ms BA, Dr K did not perform the biopsy and that it was untrue when she said that he did.

Paragraph 10b

180. The Tribunal has already found that the biopsy was taken from the right side, and that it should have been taken from the left side.

181. The notes of the meeting between Dr Martinez Higueros, Dr F and Ms BA show that Dr Martinez Higueros asserted that the biopsy had been taken from Patient B's right kidney until she was told that the initial request from the clinicians was for a left sided biopsy. At that point, Dr Martinez Higueros changed her account, saying that she had indeed taken the biopsy from Patient B's left side. She subsequently maintained that position against a body of evidence including contemporaneous documents and written and oral witness evidence showing that a biopsy was performed of the right kidney.

182. The Tribunal was therefore satisfied on balance that Dr Martinez Higueros did know that it was untrue when she said that the biopsy was taken from the left side.

Paragraph 10c

183. The Tribunal determined that it follows on from its findings at 10a and b, and that Dr Martinez Higueros accepted she conducted the procedure. It did not accept the assertion by Dr Martinez Higueros that Dr S was present. There is no evidence from witnesses or in the medical record that Dr S was involved in this procedure in any way. The Tribunal noted that during the meeting, Dr Martinez Higueros twice asserted that Dr K had carried out the procedure, before mentioning Dr S when it was pointed out to her that Dr K was not referred to in the contemporaneous records.

184. The Tribunal therefore determined that Dr Martinez Higueros knew that Dr S did not perform the procedure and was not present during the biopsy. It follows that she knew this was untrue.

Paragraph 10d

185. Dr Martinez Higueros recorded on a number of documents, as set out above, which were before the Tribunal that the biopsy had been undertaken on the right kidney. The procedure took place 3 weeks before the meeting. On the morning of the meeting Dr Martinez Higueros was shown the radiology report to show what procedure she had undertaken and the procedure the MDT had recommended.

186. Dr Martinez Higueros changed her position during the meeting. She first said the right kidney had been biopsied, but then after it was pointed out that the initial request was for a left sided biopsy, she had made a mistake in the documents and computer records and had actually performed the biopsy on the left.

187. Having regard to the documentary evidence available at the time and brought to Dr Martinez Higueros's attention during the meeting, the Tribunal was of the view that Dr Martinez Higueros knew the addendum to the Report entered at around 13:07 on 28 February 2020 stating, *"The solid lesion identified and biopsied is on the lower pole of the left kidney"* was untrue as the biopsy had been taken from the right side.

Paragraph 10e

188. For the same reasons as set out in respect of Paragraph 10d, The Tribunal determined that Dr Martinez Higueros knew that information she gave to histopathology laboratory stating that the biopsy was on the left kidney was untrue, as she performed the biopsy on the right kidney.

189. The Tribunal therefore found Paragraphs 10a, b, c, d and e of the Allegation **proved.**

<u>Paragraphs 11a, b, c, d and e of the Allegation</u>

11. Your actions as set out at paragraph:

    a. 8a(i) were dishonest by reason of paragraph 10a;

    b. 8a(ii) were dishonest by reason of paragraph 10b.

    c. 8a(iii) were dishonest by reason of paragraph 10c.

    d. 8b were dishonest by reason of paragraph 10d;

e. 9 were dishonest by reason of paragraph 10e.

190. The Tribunal considered the case of *Ivey* again. It was also mindful that Dr Martinez Higueros is of good character.

191. Contemporaneous records of the biopsy performed on Patient B, including the MDT recommendation, WHO checklist, RIS report and discharge summary all show that the biopsy was performed on the right kidney. This was supported by evidence of witnesses present during the procedure. Against this evidential backdrop, the Tribunal was of the view that subjectively, Dr Martinez Higueros knew during the meeting on 28 February 2020 that she had made a mistake. She realised that she had performed the biopsy on the right kidney instead of the left kidney. From that point on, Dr Martinez Higueros made attempts to cover up her mistake, telling untruths during the meeting, making an addendum report, and requesting the histopathology report to be updated. These attempts to cover up her mistake could have affected patient safety.

192. The Tribunal considered that an ordinary decent member of the public, fully informed of all the details of this case would consider objectively that Dr Martinez Higueros's conduct as set out above would amount to dishonest behaviour.

193. The Tribunal therefore found paragraphs 11a, b, c, d and e of the Allegation **proved.**

The Tribunal's Overall Determination on the Facts

194. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

Patient A

1. On 12 December 2019 you were requested by Dr G to perform a diagnostic left pleural aspiration ('the Aspiration') on Patient A but you performed a therapeutic right sided pleural drainage ('the Drainage'). **Determined and found proved**

2. You did not:
   a. obtain adequate clinical information to determine the intended purpose for the Aspiration, before to undertaking the Drainage; **Determined and found proved**

   b. discuss the decision to change the procedure with the referring clinicians or another interventional radiology colleague before performing the Drainage; **Determined and found proved**

   c. perform the Aspiration as requested by Dr G; **Determined and found proved**

3. Following the Drainage, you failed to:

a. update your colleagues to explain your decision to carry out the Drainage; **Determined and found proved**

b. apologise to Patient A for performing the Drainage rather than the Aspiration, during the ward meeting at around 18:00. **Determined and found proved**

4. At around 19:28 on 12 December 2019, you added an addendum to the Radiology Information System ('RIS') operative report stating 'unable to perform left side drain insertion, as requested. Decision made on right sided drain insertion. Medical team contacted' ('the Amendment'). **Determined and found proved**

5. When you made the Amendment you knew that you had not contacted the medical team to discuss your decision to perform the Drainage. **Determined and found proved**

6. Your actions at paragraph 4 were dishonest by reason of paragraph 5. **Determined and found proved**

Patient B

7. On 6 February 2020 you carried out a biopsy on Patient B's right kidney ('the Biopsy'), on which you entered a RIS report ('the Report') stating 'US confirmed solid component of the upper right renal pole lesion'. **Determined and found proved**

8. On 28 February 2020 you:

a. were interviewed by Dr C and Ms D at around 09:45 and stated that the Biopsy was:

i. performed by Dr E; **Determined and found proved**

ii. taken from the left side; **Determined and found proved**

iii. performed by Dr F and/or alternatively he was present during the Biopsy. **Determined and found proved**

b. made an addendum entry to the Report at around 13:07 stating, 'The solid lesion identified and biopsied is on the lower pole of the left kidney'; **Determined and found proved**

9. On or around 2 March 2020, you asked the histopathology department to amend the histopathology report for the Biopsy to state, 'Specimen location should be left renal lesion'. **Determined and found proved**

10. You knew that the information you:

    a. provided as set out at paragraph 8a(i) was untrue because Dr E did not perform the Biopsy; Determined and found proved

    b. provided as set out at paragraph 8a(ii) was untrue because the Biopsy had been taken from the right side; Determined and found proved

    c. provided as set out at paragraph 8a(iii) was untrue because Dr F did not perform the Biopsy and/or was not present during the Biopsy; Determined and found proved

    d. added as set out at paragraph 8b was untrue because the Biopsy had been taken from the right side; Determined and found proved

    e. provided as set out at paragraph 9 was untrue because the Biopsy had been taken from the right side. Determined and found proved

11. Your actions as set out at paragraph:

    a. 8a(i) were dishonest by reason of paragraph 10a; Determined and found proved

    b. 8a(ii) were dishonest by reason of paragraph 10b. Determined and found proved

    c. 8a(iii) were dishonest by reason of paragraph 10c. Determined and found proved

    d. 8b were dishonest by reason of paragraph 10d; Determined and found proved

    e. 9 were dishonest by reason of paragraph 10e. Determined and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

Determination on Impairment - 17/04/2024

195. The Tribunal now has to decide in accordance with Rule 22(1)(f) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') whether Dr Martinez Higueros' fitness to practise is impaired by reason of misconduct.

The Evidence

196. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. There was no further live evidence at this stage, but it did receive a further defence bundle. This included a reflection statement, references/testimonials, colleague and patient feedback, CPD/Training and Dr Martinez Higueros' Curriculum Vitae. The Tribunal heard submissions from both Ms Barbour for the GMC, and Mr Morris on behalf of Dr Martinez Higueros, and these are summarised below.

Submissions

On behalf the GMC

197. Ms Barbour reminded the Tribunal that whether Dr Martinez Higueros' fitness to practice is currently impaired was a matter for its own independent judgment, and that there was no burden of proof at this stage.

198. Ms Barbour pointed the Tribunal to s35(c) of the Medical Act which regulates matters of misconduct and reminded it that there is a two-stage process. Firstly, the Tribunal must consider whether there has been serious professional misconduct, and then, if so, whether Dr Martinez Higueros' fitness to practice is currently impaired.

199. Ms Barbour firstly asked the Tribunal to consider misconduct. She confirmed that there was no statutory definition of it, but reminded the Tribunal that they could be assisted by the expert evidence given by Dr M. She also referred to the case of *Nandi v GMC [2004] EWHC* where it was said that serious misconduct was likely to be conduct that a fellow practitioner would find 'deplorable.'

200. The Tribunal was asked to consider its findings on the facts, and was directed in particular to paragraphs 71,129,131,181, and 191 of its determination. Ms Barbour pointed out that the Tribunal found Dr Martinez Higueros' accounts to be contradictory, and varying. She said that that the Tribunal had concerns that Dr Martinez Higueros had changed her account and made attempts to cover up her mistakes. She submitted that patient safety could have been affected and that any reasonable practitioner would be appalled by her behaviour.

201. Ms Barbour submitted that Dr Martinez Higueros' actions breached fundamental tenets of the profession and referred the Tribunal to Good Medical Practice (GMP) (2013 version). She said that a number of paragraphs were engaged namely paragraphs 1,2,7,15,16(d),17,18,19,21,35,55,65,68,71 and 73, and asked the Tribunal to consider GMP in its entirety.

202. Overall, bearing in mind the proven facts, Ms Barbour submitted that Dr Martinez Higueros had breached GMP in a fundamental and wide ranging way.

203. Ms Barbour then asked the Tribunal to consider impairment. She directed it to the test for impairment as set out in paragraph 76 in the case of *CHRE v NMC & Grant (2011) EWHC 927 (Admin)* and submitted that all 4 of the limbs a), b), c) and d) were engaged in this case (These are set out in the LQC advice below).

204. Ms Barbour mentioned the case of *Meadow v GMC [2006] EWCA Civ 1390* stating that the purpose of finding that a doctor's fitness to practice is impaired is not to punish, but to protect the public. She also reminded the Tribunal that it should look forward and not back and decide if fitness to practice is impaired as of today. When deciding this, it should take into account how Dr Martinez Higueros has acted or failed to act in the past.

205. Ms Barbour pointed the Tribunal to the case of *Cheatle v GMC [2009] EWHC 645(admin)* which stated that some cases are so egregious that a doctor's fitness to practice must be impaired. The Tribunal was advised that it must focus on protection of the public and the 4 limbs as set out in *Grant,* and it could determine that a finding of impairment is necessary to maintain public confidence.

206. Turning to remediation, Ms Barbour submitted that the Tribunal must look carefully at the evidence that had been served, and the action that Dr Martinez Higueros has taken. She said that the Tribunal had to be satisfied that the risk of repetition was very low. She submitted that there is extremely limited evidence of either genuine reflections and insight, or actions to ensure that the behaviour does not happen again. She said that there were real concerns that Dr Martinez Higueros has not developed any proper insight, and this led to a risk of repetition.

207. Ms Barbour referred to the case of *Sawati v GMC [2002] EWHC (admin) circular* in relation to '*failed defences*'. In essence, she confirmed that a doctor is entitled to defend himself, and a Tribunal must not punish him for doing so, but it can weigh up what happened at the fact-finding stage when assessing insight.

208. Ms Barbour noted that the Tribunal has been provided with testimonial evidence, but pointed out that there was nothing in the testimonial statements about Dr Martinez Higueros reflecting or discussing the findings with those who provided the statements.

209. The LQC pointed out that Dr M's report did not identify all paragraphs of the Allegation as falling seriously below the necessary standard of care and asked for the views of the GMC in relation to this aspect. Ms Barbour confirmed that the Tribunal should consider the expert's opinion but did not need to '*blindly*' follow it. He is a medical expert, and parts of the Allegation relate to dishonesty. She also referred to the case of *Schodlok v GMC [2015]*

EWCA Civ 769 stating that unless there was a large number of acts or omissions alleged then, in relation to misconduct, they should be considered separately not cumulatively.

On behalf Dr Martinez Higueros

210. Mr David Morris, Counsel, stated that Dr Martinez Higueros accepted that she had been found guilty of misconduct and that it was inevitable that a finding of impairment would follow. He drew the Tribunal's attention to Dr Martinez Higueros' reflective statement that says;

> *'I fully understand that on the basis of their findings the Tribunal is bound to find that I have fallen seriously below standard and that I must be sanctioned in order to protect the public.'*

211. Mr Morris pointed out that there had been findings relating to both clinical failings and matters of dishonesty. He accepted that the dishonesty matters were more serious. He said that, assuming the Tribunal finds those matters to fall seriously below the standards expected, then a finding of misconduct would follow. Mr Morris asked the Tribunal to accept that there was a spectrum of misconduct.

212. Mr Morris directed the Tribunal to the findings and the expert report as regards the clinical failings in relation to Patient A. He pointed out the expert's evidence stated that the conduct of Dr Martinez Higueros in relation to paragraph 1 and 2 of the Allegation was found to be below the standard of care expected, but not seriously below. Dr M had confirmed that the procedure was conducted without issue, and no harm was done to the patient. Mr Morris accepted that Dr M found some clinical aspects of Patient A's care to be seriously below the standard required, namely the failure to update colleagues after the procedure, and to apologise to the patient.

213. With regards to Patient B, Mr Morris again directed the Tribunal's attention to the expert report and asked them to note that Dr M did not find that any clinical aspects fell short of the standard of care required. The expert had given Dr Martinez Higueros *'the benefit of the doubt'* because of some of the issues with communication at the hospital and he also stated that the biopsy was skillfully carried out.

214. Mr Morris referred the Tribunal to the case of *Ahmedsowida v General Medical Council* [*2021] EWHC 3466,* which builds on the case of *Schodlok* mentioned above. It was decided in that case a Tribunal was wrong to cumulate acts or omissions to make a finding of serious misconduct, and also to have elevated matters from misconduct to serious misconduct because there were other matters of serious misconduct before it. As there was not a volume of acts in this case, nor a pattern of behaviour, then this Tribunal should consider each paragraph separately.

215. Mr Morris then asked to the Tribunal to consider the matters relating to dishonesty. He submitted that as far as Patient A was concerned, this related to when Dr Martinez Higueros had said that the medical team had been contacted when they had not. He submitted that there was no suggestion that the dishonesty had caused a risk of harm to Patient A.

216. With regards to Patient B, Mr Morris accepted that the dishonesty was of a more serious level. He stated that the dishonesty was about one assertion that was repeated three times, namely that she had conducted the biopsy on the left kidney. He accepted that this could have impacted the patient, as it could had led to the wrong operation taking place, or the need to repeat the biopsy on the other side.

217. Mr Morris asked the Tribunal to consider the context of the interview [on 28 February 2020] with Dr Martinez Higueros at the hospital. It was an interview with two senior people. Dr Martinez Higueros was a locum with no security of tenure, was under supervision, and was not informed in advance of the meeting. English was her second language, and she did not have anyone to support her in the meeting. He also submitted that the addendum entry and the request to the histopathology department that they amend her report had no real prospect of a successful cover up, and this illustrates Dr Martinez Higueros's state of mind at the time.

218. Mr Morris then addressed the Tribunal in relation to impairment so far as the clinical findings were concerned. He drew the Tribunal's attention to Dr Martinez Higueros' reflection statement in which, for example, she had accepted that '*things should have been done differently'*. He submitted that Dr Martinez Higueros has shown insight and demonstrated remediation. Mr Morris stated that Dr Martinez Higueros had conducted a large of amount of procedures, as evidenced by the logbooks. She had received positive 360 degree feedback from both patients and colleagues and had kept her skills and knowledge up to date. He submitted that the risk of repetition so far as the clinical issues are concerned, is low.

219. Acknowledging that dishonesty is difficult to remediate, Mr Morris nevertheless reminded the Tribunal that Dr Martinez Higueros is of previous good character in terms of both her integrity and practice. He confirmed that there had been no adverse findings before or since. No other concerns about her probity have been raised.

220. Mr Morris confirmed that Dr Martinez Higueros accepted the findings of dishonesty and was not seeking to go behind the Tribunal's decision. He directed the Tribunal to the reflective statement where Dr Martinez Higueros recognised the seriousness of dishonesty and accepted that a sanction would have to be imposed.

221. Mr Morris asked the Tribunal to note the number of courses that Dr Martinez Higueros had attended and directed the Tribunals' attention to the important courses relating to Self-reflection and Developing Insight, Professionalism for Doctors, and Probity for Doctors.

222. Mr Morris summarised by saying that the dishonesty episodes took place 4 years ago and Dr Martinez Higueros had continued to practice since then, with no concerns raised.

The Relevant Legal Principles

223. The LQC gave advice at this stage, which is set out below.

224. The Tribunal is considering a matter that alleges both clinical misconduct and instances of dishonesty. The Tribunal found the factual matters proved in August 2023. The Tribunal must now consider if Dr Martinez Higueros' fitness to practice is currently impaired.

225. The Tribunal is reminded there is no burden or standard of proof to adopt at this stage and that decision as to impairment is a matter for the Tribunal's judgement alone.

226. In approaching this decision, the Tribunal will be mindful of the fact that there are 2 parts to the impairment stage of the process. Firstly, the Tribunal must decide whether the facts as found proved amount to misconduct, and then whether the finding of that misconduct leads to a finding of current impairment.

227. 'Misconduct' has no statutory definition. It is a matter for the judgement and experience of the tribunal. However, in the case of *Roylance v GMC [No 2] [2000] 1 AC 311* it was said that 'misconduct' should be 'serious misconduct' before the Tribunal should move to consider fitness to practise. The word 'serious' should be given its ordinary meaning. This case stated that misconduct is:

> *'some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

228. The Tribunal should therefore take into account whether Dr Martinez Higueros has departed from the standards sets out in Good Medical Practice (GMP). As the matters found proved took place in 2019 and 2020 then the Guidance dated 2013 should be applied, rather than the new Guidance which was issued in January 2024.

229. The Tribunal has received evidence from an expert, Mr M, and his opinion should be taken into account at this stage. The Tribunal should consider whether the expert has sufficient expertise to express the opinions that he has on the topics that he has. A tribunal

does not have to accept expert opinion, but if it decides not to accept it, then it must set out our reasons why that is the case.

230. There is also the case of *Nandi v GMC [2004] EWHC* where *Collins J* said that misconduct is conduct which would be regarded as 'deplorable' by fellow practitioners.

231. The Tribunal should have regard to the case of *Schodlok v GMC [2015] EWCA Civ 769.* This case considered whether a Tribunal could find that acts which on their own were misconduct, but not serious misconduct, cumulatively could amount to serious misconduct. The case states that generally it cannot. If, however, there are a large number of findings of non-serious misconduct, particularly where they show a pattern of behaviour, then it is open in principle for a tribunal to find that, cumulatively, they can be regarded as serious misconduct capable of impairing a doctor's fitness to practice. In similar vein, the case of *Ahmedsowida 2021 EWHC 346 admin* considered whether a misconduct matter could be 'elevated' to serious misconduct if considered with other matters of serious misconduct. The Tribunal is advised that in this case, there is not a pattern of behaviour or a volume of acts or omissions and so each paragraph should be considered separately.

232. If, having decided that there is misconduct as defined, then the Tribunal should consider whether its findings of fact show that Dr Martinez Higueros' fitness to practise is currently impaired.

233. Whilst there is no statutory definition of impairment, the Tribunal is assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC & Grant (2011) EWHC 927 (Admin)* ('Grant'). Dame Smith sets out some features that are likely to be present when impairment is found. These are where the doctor has in the past or is liable in the future to

a. act so as to put a patient or patients at unwarranted risk of harm.

b. bring the medical profession into disrepute.

c. breach one of the fundamental tenets of the medical profession; and/or

d. Have acted dishonestly and or is liable to do so in the future.'

234. It is not necessarily the case that having found misconduct, impairment must follow.

235. The Tribunal is reminded that part of the Allegation relates to dishonesty. In the case of *GMC v Nwachuka 2017 EWHC 2085 Admin* it was confirmed that it is unusual for dishonesty not to result in impairment. Also, the case of *Nkomo v GMC 2019 EWHC 2625 admin* states that dishonesty is generally held to be difficult to remediate. This is because, unlike with clinical errors, where further practice and/or teaching would likely show a

practitioner the correct method of practice, the nature of dishonest behaviour goes more to the practitioner's *character* than learning. Clinical and personal mitigation therefore hold less weight in such cases.

236. Having said that, the Tribunal must note that each case is on its facts, - impairment does not necessarily follow findings of dishonesty. The Tribunal should look at the nature of the dishonesty, the need to uphold public confidence, and what Dr Martinez Higueros has done to remediate.

237. The Tribunal must determine whether the Doctor's fitness to practice is impaired as of today and looking forward, taking into account its findings, and any relevant factors since. The Tribunal should consider whether the matters are remediable, whether they have been remediated, and the likelihood of repetition.

238. To assist them in this decision, the Tribunal must determine where the doctor has demonstrated insight, and if so to what extent. The Tribunal is advised that it should not necessarily equate the maintenance of innocence with a lack of insight. A doctor is entitled to defend himself. It is possible that a doctor can demonstrate that he fully appreciates the gravity of the matters alleged and it is proper to take into account a doctor's understanding of, and attitude toward the underlying allegation. (See *Yusuff v General Medical Council [2018] EWHC 13 (Admin)).* If, however, a doctor defends an allegation of primary fact by giving dishonest evidence and by deliberately seeking to mislead a tribunal, then that conduct is relevant to consideration of impairment and fitness to practise in the future. However, if a doctor does no more than put the GMC to proof, then that should not be held against him during the impairment and sanctions stages. *(Sayer v General Osteopathic Council [2021] EWHC 370 (Admin)).* The more recent case of *Sawati v GMC [2022] EWHC (admin) circular* confirms that a tribunal should not punish a doctor for defending himself, but it can weigh up what happened at stage one when assessing insight.

239. A doctor could show that they have insight if they:

1. Demonstrate that they have reflected on their own performance or conduct and understand what went wrong.
2. Accept they should have behaved differently in the circumstances.
3. Demonstrate that they understand the impact or potential impact of their performance or conduct.
4. Demonstrate empathy for any individual involved.
5. Take timely steps to remediate and identify how they will act differently in the future to avoid similar issues arising.

240. The Tribunal took into account Dr Martinez Higueros' good character during stage one of this case and was furnished with references provided on her behalf. The Tribunal is reminded that they can again be considered when making a determination on impairment.

There is also now a further bundle from the defence that includes testimonials, evidence of appraisals, and details of courses that Dr Martinez Higueros has attended. The Tribunal should consider all of these and attach such weight to them as it considers appropriate.

241. As well as considering the features set out in *Grant,* the Tribunal must also determine whether the need to uphold professional standards and maintain public confidence would be undermined if a finding of impairment was not found. It is crucial that the Tribunal is mindful of the overarching objective of the GMC which is set out in s1 of the Medical Act 1983 and requires the Tribunal to:

a. Protect, promote and maintain the health, safety and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

The Tribunal's Determination on Impairment

Misconduct

242. The Tribunal considered whether the conduct found proved in this case amounted to misconduct. It reminded itself of the facts of each paragraph and considered them separately. It considered GMP and the expert report.

Patient A

243. The Tribunal firstly considered the paragraphs that related to Patient A.

Paragraphs 1 and 2(i),2(ii) and 2(iii)

244. These paragraphs all relate to Dr Martinez Higueros carrying out the procedure on Patient A. The Tribunal had found that Dr Martinez Higueros was asked to perform a diagnostic left pleural aspiration on Patient A, but instead performed a therapeutic right sided pleural drainage. It also found that she failed to both obtain adequate clinical information before undertaking the drainage, and to discuss the decision to change the procedure with referring colleagues.

245. The Tribunal had regard to the evidence of Dr M, the expert in this case. It noted that these paragraphs related to clinical matters. He took the view that Dr Martinez Higueros' actions as set out in paragraphs 1 and 2(i), (ii), and (iii) were below the standard expected,

but not seriously so. In answer to the question '*Explain why they were below, but not seriously?'* he stated:

> • *It was perfectly reasonable to decide it was unsafe to aspirate the left effusion but this should have been discussed beforehand with the referring clinicians or possibly another interventional radiology colleague if that was not possible.*
>
> • *The whole point of the WHO checklist is to prevent mistakes and omissions. Done properly it is a very powerful tool for patient safety but it requires the engagement of all those involved in patient care during procedures. Dr Martinez Higueros should have been fully involved during that discussion. It doesn't always have to be the doctor who leads it. Instead it seems she was ultrasounding the patient whilst it took place. In my experience such lack of engagement has a significant effect on other members of "the team". It ceases to be a "team" and there is a mental disengagement. This is the only explanation I can think of why not a single nurse or radiographer question the decision to insert a catheter drain when their own whiteboard stated that the procedure was an aspiration.*
>
> • *It is difficult to explain Dr Martinez Higueros' thought processes here. The difficulties with CERNER certainly played some role. The rarity of a pleural aspiration request as opposed to a drainage request to interventional radiology might also have played a part, but all the evidence is that she knew that an aspiration rather than a catheter drainage procedure had been requested immediately prior to the patient's arrival. The decision to insert a right sided catheter drain suggests that she had no idea what the clinical reason for the request was and why she was asked to perform it.*
>
> • *Radiologists are clinicians and should not be carrying out invasive procedures on patients unless they know why and that intervention is justifiable, the benefits outweighing the risks. However in this case she explained her decision to carry out the procedure on the right rather than the left and justified it on safety grounds which she is perfectly right to do even if those grounds proved subsequently insubstantial. She also carried out the procedure technically well and the patient came to no lasting harm*

246. Although carried out on the wrong side of Patient A, Dr M confirmed that the procedure was carried out technically well. In view of this evidence, the Tribunal did not find that Dr Martinez Higueros' actions under any of these sub paragraphs amounted to serious misconduct.

<u>Paragraph 3 a and b</u>

247. These paragraphs relate to what took place after the procedure on Patient A. The Tribunal had found that Dr Martinez Higueros failed to update her colleagues after the procedure or apologise to Patient A for not carrying out the requested procedure.

248. The Tribunal had regard to the evidence in Dr M's report. He concluded that Dr Martinez Higueros' failure to explain her decision to conduct the procedure on the right-hand side of Patient A as requested to colleagues and apologise to the patient were seriously below the standard required. When asked in his report to explain this view he stated:

> • *When the referring clinicians were made aware of the unrequested right sided drainage catheter they asked for a meeting on the ward which took place around 7pm on the 12th December 2019. Dr Martinez Higueros was accompanied to the ward by a radiology colleague. She had an opportunity at that meeting to explain her actions and apologise for the mistake. Again, she doesn't appear to have fully engaged with the meeting, performing another ultrasound on during some part of it. She stated that the drain had been placed because that what was requested on CERNER. The evidence suggests that this explanation was disingenuous. She also failed to explain why it had been inserted into the right effusion rather than the left. She appears to have refused to answer this question. …*

249. The Tribunal accepted the opinion of Dr M with regard to these paragraphs that Dr Martinez Higueros' actions were seriously below the standard expected. It also had regard to GMP at this stage, which is set out in further detail below. The Tribunal determined that Dr Martinez Higueros did not discuss the procedure with her colleagues until she was told to check on Patient A and soon after attended a ward meeting with the referring team. Even at that stage Dr Martinez Higueros remained evasive. Dr Martinez Higueros accepted that she did not apologise to Patient A, because she felt that there was nothing to apologise for. The Tribunal concluded that Dr Martinez Higueros' conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

250. In the circumstances, the Tribunal considered that Dr Martinez Higueros' actions were, and would be considered by fellow professionals and the public to be, wholly unacceptable. In light of this, the Tribunal concluded that Dr Martinez Higueros' actions in relation to these sub paragraphs of the Allegation amounted to misconduct, which was serious.

<u>Allegation 4, 5 and 6</u>

251. These and other paragraphs of the Allegation relate to dishonesty. The Tribunal considered the opinions of Dr M in his expert report on the relevant probity issues. The Tribunal noted that he is not an expert in the field of professional ethics or human resources and, whilst it took into account his opinions on the extent to which Dr Martinez Higueros had

acted dishonesty, it exercised its own independent judgment. It had regard to all of the evidence in the case when considering dishonesty.

252. These paragraphs relate to an addendum to the RIS operative report that Dr Martinez Higueros made after the procedure had been carried out on Patient A. The Tribunal again reminded itself of its findings at the facts stage. Dr Martinez Higueros added the addendum to her report stating '*unable to perform left side drain insertion, as requested. Decision made on right sided drain insertion. Medical team contacted.'* The Tribunal heard evidence that she did not make contact with the medical team and determined that the content of the addendum was untrue and dishonest.

253. The Tribunal had regard to the evidence in Dr M's expert report. He had taken the view that Dr Martinez Higueros' actions in amending the report after the ward meeting was seriously below the standard required. He stated:

> ' *The alteration of facts on a clinical report is bad enough but to do so to make it fit a incorrect narrative is seriously below the standard expected of any doctor.'*

254. The Tribunal had regard to GMP at this stage, which is set out in further detail below. It also noted the opinion of Dr M. The Tribunal noted that Dr Martinez Higueros had amended a hospital record and acted dishonestly in doing so. It determined that the false entry could have compromised patient safety and gave a misleading and inaccurate account to hospital colleagues. There was a potential risk of harm to Patient A. The Tribunal decided that acting dishonestly in this way was serious misconduct.

255. In the circumstances, the Tribunal considered that Dr Martinez Higueros' actions were, and would be considered by fellow professionals and the public to be, wholly unacceptable. In light of this, the Tribunal concluded that Dr Martinez Higueros' actions in respect of these sub paragraphs fell far below the standards expected and amounted to serious misconduct.

256. When considering Dr Martinez Higueros actions in relation to Patient A, the Tribunal also had regard to GMP when deciding whether her actions constituted misconduct. It determined that several paragraphs of GMP were relevant namely, 1, 2, 15, 16d, 17, 19, 21, 35, 55, 65, 68 and 71. They are set out below:

> *'1 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*, are honest and trustworthy, and act with integrity.*

2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

> *a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
> *b promptly provide or arrange suitable advice, investigations or treatment where necessary*
> *c refer a patient to another practitioner when this serves the patient's needs.8*

16 In providing clinical care you must:

> *a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs9*
> *b provide effective treatments based on the best available evidence*
> *c take all possible steps to alleviate pain and distress whether or not a cure may be possible10*
> *d consult colleagues where appropriate*
> *e respect the patient's right to seek a second opinion*
> *f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications*
> *g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship..*

> *17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research.*

> *19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*

21 Clinical records should include:

a relevant clinical findings
b the decisions made and actions agreed, and who is making the decisions and agreeing the actions
c the information given to patients
d any drugs prescribed or other investigation or treatment
e who is making the record and when.

35 You must work collaboratively with colleagues, respecting their skills and contributions.3

55 You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:

a put matters right (if that is possible)
b offer an apology
c explain fully and promptly what has happened and the likely short-term and long-term effects.

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate..

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents.22 You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.
b You must not deliberately leave out relevant information.'

Patient B

257. The Tribunal secondly considered the paragraphs that related to Patient B.

Paragraph 7

258. The Tribunal previously determined that Dr Martinez Higueros carried out a biopsy on Patient B's right kidney and entered that fact on her RIS operative report. Dr Martinez Higueros throughout the hearing insisted that she carried out a left kidney biopsy. However, the Tribunal having considered all the written and oral evidence and contemporaneous medical documents found that Dr Martinez Higueros had conducted a right biopsy.

259. The Tribunal had regard to the evidence in the expert report, although it noted that this paragraph was not making an allegation in itself. Dr M gave his opinion about the biopsy that had taken place and described it:

> '*The biopsy was carried out skillfully with no complications. Indeed the resultant histopathology was serendipitous as it answered the question regarding the right renal cysts nature and avoided a prolonged period of follow up.'*

260. The Tribunal was concerned that Dr Martinez Higueros had conducted a biopsy on the wrong side, but noted this did not form part of an allegation in this paragraph. Dr M had confirmed that the biopsy was carried out skillfully.

261. The Tribunal did not find that Dr Martinez Higueros' actions in relation paragraph 7 amounted to serious misconduct.

<u>Paragraph 8a(i)(ii)(iii), Paragraph 10a, b, and c and Paragraph 11a, b and c</u>

262. These paragraphs relate to an interview that took place between Dr Martinez Higueros, Dr F and Ms BA on 28 February 2020. The Tribunal found that during this interview, Dr Martinez Higueros had made a number of claims that were not true, namely that the biopsy was performed by Dr E, was taken from the left kidney of Patient B, and Dr F was present during the biopsy. The Tribunal found that Dr Martinez Higueros had acted dishonestly when making these claims.

263. The Tribunal was also concerned that Dr Martinez Higueros had maintained throughout her written and oral evidence that Ms BA was not present at the meeting which it found to be untrue. It was troubled that Dr Martinez Higueros was attacking the credibility of fellow professionals in this way.

264. The Tribunal noted Dr M's concerns about the way the interview was conducted, a matter that was raised by Mr Morris in his submissions. These issues were considered carefully when the Tribunal made its finding of fact. The Tribunal decided, after hearing all the evidence that Dr Martinez Higueros was dishonest during the meeting. The Tribunal reconsidered this issue in assessing whether Dr Martinez Higueros dishonesty amounts to serious misconduct. It considered the context of the interview and Dr M's

concerns to decide if they offered any degree of mitigation. The Tribunal heard evidence from Dr F, Ms BA and Dr Martinez Higueros about the context and content of the interview. It decided at the facts stage that, having been alerted to a potentially serious incident, Dr F was entitled to make urgent enquires to establish the basic facts, and Dr Martinez Higueros, during her oral evidence confirmed that she had not felt coerced.

265. The Tribunal decided that acting dishonestly in this way was serious, and breached aspects of GMP, set out in further detail below. It determined that such dishonesty in a clinical setting could have compromised patient safety and given a misleading and inaccurate account to hospital colleagues.

266. In the circumstances, the Tribunal considered that Dr Martinez Higueros' actions were, and would be considered by fellow professionals and the public to be, wholly unacceptable. In light of this, the Tribunal concluded that Dr Martinez Higueros' actions, as far as these sub paragraphs are concerned fell far below the standards expected and amounted to serious misconduct.

Paragraph 8b, Paragraph 9, Paragraph 10d, e and Paragraph 11d,e

267. These paragraphs relate to an addendum to the RIS system and an email that Dr Martinez Higueros sent to the histopathology department some time after the procedure had been carried out. The Tribunal found that Dr Martinez Higueros made an addendum entry stating, '*The solid lesion identified and biopsied is on the lower pole of the left kidney'.* It also found that she asked the histopathology department to amend her report for the biopsy to state; *'Specimen location should be left renal lesion.'*

268. The Tribunal was concerned that Dr Martinez Higueros maintained throughout the hearing that she had conducted a left kidney biopsy and claimed that she was amending earlier clerical errors on her part. The Tribunal had found that there was overwhelming evidence that she had carried out a right kidney biopsy.

269. The Tribunal noted Dr M's report. When posed the question as to which of her actions were seriously below the standard during Patient B's care he stated:

> *'Her post meeting amending of reports that altered the side of biopsy and therefore the side of the histo-pathological tumour. Also her contact with the histopathology department to amend their report in the same manner. This could have seriously harmed and did lead to repeat biopsy.'..*
>
> *'It could have led to the wrong operation or ablation being performed and did lead to repeat right renal biopsy which would have been unnecessary if she had told the truth and not altered the reports. This therefore raises probity concerns about Dr CMH'…*

270. The Tribunal accepted the opinion of Dr M that these actions could have impacted on patient safety. Dr Martinez Higueros' actions were seriously below the standard expected. It had regard to GMP at this stage and decided that a number of paragraphs were breached. The Tribunal noted that Dr Martinez Higueros had added an addendum to a hospital record, asked for an amendment on another and had acted dishonestly in doing so. It determined that these entries could have compromised patient safety and gave a misleading and inaccurate account to hospital colleagues. There was a clear risk of harm to Patient B. The Tribunal again decided that acting dishonestly in this way was serious.

271. The Tribunal noted that Dr Martinez Higueros had acted dishonesty in a clinical setting, and therefore the Tribunal again considered that Dr Martinez Higueros' actions were and would be considered by fellow professionals and the public to be, wholly unacceptable. In light of this, the Tribunal concluded that Dr Martinez Higueros' actions so far as these sub paragraphs are concerned amounted to serious professional misconduct.

272. When considering Dr Martinez Higueros actions in relation to Patient B, the Tribunal also had regard to GMP when deciding whether her actions constituted misconduct. It determined that several paragraphs of GMP were relevant namely, 1, 1, 16d, 17, 19, 21,35, 65, 68 and 71. They are set out above.

Impairment by reason of misconduct

273. The Tribunal, having found that some of the facts found proved amounted to serious misconduct, went on to consider whether, as a result of that misconduct, Dr Martinez Higueros's fitness to practise is currently impaired. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective.

274. The Tribunal considered that all the limbs of the test as adopted in the case of Grant (and set out above) were applicable in this case in that Dr Martinez Higueros had put patients at risk of harm, brought the medical profession into disrepute, breached fundamental tenets of the medical profession, and had acted dishonestly.

275. The Tribunal considered firstly whether Dr Martinez Higueros' misconduct was remediable. It took into account the case of *Nkomo* (set out above) and recognised that dishonesty was difficult to remediate. It also noted that there had been a number of matters of dishonesty within a clinical setting. It decided that it would be difficult for Dr Martinez Higueros to remediate her actions but considered what steps she had taken to do so.

Insight

276. In determining whether Dr Martinez Higueros had remediated her misconduct, the Tribunal considered the level of insight evidenced. It acknowledged that Dr Martinez Higueros was entitled to deny the allegations against her and recognised that she continues to do so. The dishonesty allegations are a fundamental part of this case. Dr Martinez Higueros actively denied primary facts around her treatment of Patients A and B throughout the hearing against a considerable backdrop of evidence which indicates that her position was unreasonable. The Tribunal considered Dr Martinez Higueros' continued denials to be implausible. It decided therefore that her rejected defence was relevant when assessing her level of insight. The Tribunal was concerned that her accounts changed during the hearing and had noted this at paragraphs 71,129,131,181 and 191 of its facts determination. It decided that she gave varying and contradictory accounts and that they were an attempt to cover up her clinical failings.

277. The Tribunal was also concerned that Dr Martinez Higueros gave accounts that could have affected her colleagues and called their probity into question. For example, she maintained that Dr F conducted the interview with her on her own, and Ms BA was not present. This conflicted with the evidence and the notes of the meeting. Also, she changed her accounts of her contact with Dr L. Initially Dr Martinez Higueros stated that Dr L had asked her to perform a drain on Patient A's right side when spoken to by the requesting team and Dr F during the ward meeting which took place following the procedure on Patient A. In her later responses she said that she had not spoken to Dr L at all. In oral evidence she accepted that she had done so but claimed that the conversation was merely informal.

278. In summary, having regard to the above paragraphs, while noting that Dr Martinez Higueros was entitled to deny the Allegation the Tribunal decided that it could consider her defence and the way it was conducted when assessing insight.

279. Dr Martinez Higueros submitted a reflective statement dated 11 April 2024 which the Tribunal considered carefully. In the statement, Dr Martinez Higueros accepts that in relation paragraphs 1 and 2 of the Allegation *'things should have been done differently*'. However, Dr Martinez Higueros did not reflect in her statement on the events and her conduct in relation to paragraphs 1 and 2, nor the risk of harm to Patient A and potential impact on her colleagues. In relation to paragraphs four, five and six, she simply states:

> *'I accept that dishonest record keeping is wholly unacceptable. It can present safety risk for patients. It inevitably damages the profession and undermines the trust and confidence the public must have in it.'*

In relation to paragraphs 7- 11, Dr Martinez Higueros explains the importance of maintaining public confidence and that she understands the Tribunal's findings of dishonesty are very serious.

280. Overall the Tribunal found Dr Martinez Higueros' reflective statement to be brief, couched in general terms and not specifically related to the paragraphs of the Allegation. In particular, Dr Martinez Higueros does not consider in any detail the potential impact of her actions and dishonesty on Patients A and B and on the standing of her colleagues and the medical profession. Also, Dr Martinez Higueros reflections are silent on how she would prevent a similar situation arising again and the mechanisms she has in place to ensure there is no repetition.

281. The Tribunal noted the submissions made on Dr Martinez Higueros' behalf. Through her counsel, Mr Morris, she confirmed that accepted the decisions of the Tribunal.

282. In light of all the above, the Tribunal determined that Dr Martinez Higueros had demonstrated limited insight. There are gaps in her insight which need to be addressed.

Remediation and Risk of Repetition

283. The Tribunal noted that Dr Martinez Higueros was of good character, and that there had been no similar incidents before or since. It was 4 years since the incidents took place. There were a number of positive testimonials provided on her behalf. They span the period of time between 2018 to 2023, the incidents having taken place in 2019-2020. For example,

> *'Dr CA*
> *Clinical Lead for Microbiology*
>
> *'In my view, Dr Martinez has demonstrated commitment to the Trust policies and engagement to the GMC professional standards required to her position...*
>
> *She showed proactive attitude towards learning and improving, genuine interest for patient safety and quality, as well* ***as*** *maintaining good communication with patients and colleagues….*
>
> *I have not been aware of any probity concern affecting Dr Martinez performance per annual appraisal feedbacks.*
> *I am aware of the GMC investigations, and aware my opinion can be submitted to the GMC/MPTS.'*
>
> …..
>
> *'Mr DA*
> *RN Charge Nurse*

I have known Dr. Claudia Martinez from June 2018 to February 2019. I was working as the Charge Nurse, while she was a Senior Clinical Fellow in the Interventional Radiology department at Guys & St Thomas' NHS Foundation Trust.

As the lead nurse in the interventional radiology, I have shared with Dr. Claudia Martinez the day-to-day work in the IR suite which was one of the busiest IR units in London….

The main aspects to highlight of her professional character is that Dr. Martinez workswell into the team, friendly with her peers as well as with all other staff in the department and has an excellent rapport with the patients. As far as I am aware, there has not been any probity or other concern in her practice.
…..

Dr. U

I knew Dr. Claudia Martinez from October 2019 to February 2020 while she was working as a Locum Consultant in Interventional Radiology at Chelsea and Westminster Hospital, London, UK….#

While we had separate roles in the Radiology Department, I found Dr. Martinez to an approachable, friendly, and respectful team member. I did not personally witness or experience any event that would call into question her probity or professionalism.'

284. The Tribunal also noted the logbooks that show that Dr Martinez Higueros has conducted a large range of procedures at three different NHS Trusts, and the positive 360 degree feedback report from 2022-2023, where Dr Martinez Higueros was marked as 'good' or 'outstanding' in all competencies. There were positive comments from both colleagues and patients. For example,

'Dr Martinez is passionate about her work and displays empathy towards dealing with patients. She keeps herself upto date with her knowledge and is always reliable."
…..
Dr Martinez is very helpful and is always available to help and support when asked. Her clinical experience and enthusiasm for teaching is outstanding.She is easily approachable and is an important team player.
…..
Dr. Martinez is a very good colleague. Very happy to help others. Keeps clinical knowledge uptodate and is a good team player.
….
Dr Martinez is a very approachable member of the team, she is very keen to take on extra work and cover extra lists for a

sickness etc. Dr martinez is also very keen to spread knowledge throughout our team!'

285. The testimonials, and the feedback from both patients and colleagues show that Dr Martinez Higueros is a competent doctor and had been delivering good patient care.

286. The Tribunal also noted the CPD courses that Dr Martinez Higueros has attended. They demonstrate that Dr Martinez Higueros has been keeping her clinical skills and knowledge up to date. She had also attended some sessions on record keeping.

287. The Tribunal's main concern related to the matters of dishonesty, and it noted that Dr Martinez Higueros attended courses of relevance, namely, '*Probity for Doctors,' 'Professionalism for Doctors; when things go wrong'* and *'self-reflection and developing insight'* The Tribunal considered that attendance on these courses showed efforts to remediate. However, the Tribunal had not received any evidence from Dr Martinez Higueros as to what she had learned from those courses, and what, if anything, she was now doing differently. It concluded that there was only a partial demonstration of remediation.

288. In light of all the above, the Tribunal decided that, notwithstanding the good character and positive testimonials, owing to the limited insight, partial remediation, and the remaining risk of repetition, then a finding of impairment was necessary in Dr Martinez Higueros' case. The Tribunal had found that she acted dishonestly, and it decided that a member of the public would be concerned if a determination of impairment were not found. It determined that a finding of impairment was necessary to uphold the overarching objective, namely, to protect, promote, and maintain the health safety and wellbeing of the public, promote, and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for members of the profession.

289. The Tribunal therefore determined that Dr Martinez Higueros' fitness to practice is currently impaired by reason of misconduct.

Determination on Sanction - 19/04/2024

290. Having determined that Dr Martinez Higueros' fitness to practise is impaired by reason of her misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

291. The Tribunal received both written and oral submissions from Ms Barbour and Mr Morris, and these are summarised below.

Submissions

On behalf of GMC

292. Ms Barbour reminded the Tribunal that the decision as to the appropriate sanction to impose is a matter for the tribunal exercising its own independent judgement, and that the submissions are intended to assist it in coming to that decision.

293. Ms Barbour told the Tribunal that it should be assisted by the Sanctions Guidance (SG). At paragraph 14 it states that the main reason for imposing sanctions is to protect the public, which encompasses the statutory overarching objective.

294. Ms Barbour reminded the Tribunal that any sanction should be proportionate, but that the reputation of the profession as a whole is more important than the interests of an individual doctor. It is crucial that public confidence in the profession is maintained.

295. Ms Barbour addressed the Tribunal on the case law in relation to dishonesty. She stated that dishonesty cases lie at the top end of the spectrum of gravity of misconduct, but that each case must be considered individually. Erasure was not inevitable, and a lesser sanction may suffice. A tribunal would need to consider if there was compelling evidence of insight, whether the dishonesty appears to be out of character or somewhat isolated in its duration or range, and the extent to which the reputation of the profession would be damaged if the doctor continued to practice. She also stated that dishonesty is particularly serious when it occurs in the performance of a doctor's duties.

296. Ms Barbour stated that the gravamen of this case is the dishonesty. In the cases of both patients, the dishonesty arose from a desire to cover up clinical mistakes. That meant Dr Martinez Higueros placing her own interests before those of the patients.

297. Ms Barbour referred to the incident involving Patient A. She said that Dr Martinez Higueros was evasive at the ward meeting. She should have been upfront about the mistake and apologised to the patient. This failure in respect of the duty of candour is a clinical issue - one that was found to be serious misconduct. Ms Barbour submitted that, although some aspects of clinical work were up to standard, Dr Martinez Higueros sought to disguise her mistake by stating that the medical team had been contacted before the procedure took place.

298. Ms Barbour also referred to the incident involving Patient B. She reminded the Tribunal that Dr Martinez Higueros did not carry out the requested procedure. Again, this was not in and of itself serious professional misconduct. The misconduct arose after the mistake was brought to her attention, when she lied about what had happened. Ms Barbour reminded the Tribunal that Dr Martinez Higueros had asserted that Ms BA was not present in the interview, which it found to be untrue. Ms Barbour said that she been told not to work without supervision, which might provide an explanation as to why she initially told Dr F that the procedure on Patient B was carried out not by her, but a senior colleague. The dishonesty at

that meeting was compounded when Dr Martinez added an addendum to her report, and when she contacted the histopathology team. These actions could have caused very serious harm to Patient B and did lead to a repeat biopsy.

299. Ms Barbour submitted that this type of dishonesty directly poses a risk to patient safety, and which must therefore fall at the top end of the spectrum of seriousness. It was sustained, and repeated. It also could have had a very serious impact on the careers of a number of other professionals.

300. Ms Barbour referred the Tribunal to potential mitigating factors in this case, and the SG at paragraphs 25-49. She said that Dr Martinez Higueros had no previous findings against her, and that there were testimonials written on her behalf. She said that those testimonials were at odds with the findings against her, and there was no reference in them to Dr Martinez Higueros having reflected on the facts found proved or taking steps or measures towards avoiding repetition. It was for the Tribunal to decide what weight to give them.

301. Ms Barbour accepted that Dr Martinez Higueros was new to the role at the time but said that this could not excuse dishonesty. She noted that there had been a lapse of time (4 years) since the incident but pointed out that the case could have been heard in 2022, but Dr Martinez Higueros successfully applied for an adjournment as she was not ready to proceed.

302. Ms Barbour asked the Tribunal to consider insight and drew the Tribunal's attention to paragraphs 45-49. The Tribunal had found that Dr Martinez Higueros has only limited insight. Notwithstanding that English is not her first language, Dr Martinez Higueros had expressed herself well and Tribunal has noted her language skills. The Tribunal should consider this issue carefully.

303. Ms Barbour pointed out that paragraph 46 states that a doctor is likely to have insight if they:

> a) accept they should have behaved differently (showing empathy and understanding)
> b) take timely steps to remediate and apologise at an early stage before the hearing
> c) demonstrate the timely development of insight during the investigation and hearing.

304. Ms Barbour submitted that Dr Martinez Higueros has not done any of the things above. She had sought to obfuscate, and thus drew others into the firing line for example, by stating that only Dr F was present at the interview, and putting a junior doctor, Dr L, at risk of unwarranted criticism.

305. Ms Barbour asked the Tribunal to note that some of the courses that Dr Martinez Higueros had attended pre-date the evidence she gave at the hearing, and do not appear to have helped her in addressing her insight. She pointed out that the Tribunal has not received any evidence from Dr Martinez Higueros as to what she had learned from those courses, and what, if anything, she was now doing differently. It had concluded that there was only a partial demonstration of remediation.

306. Ms Barbour referred the Tribunal to potential aggravating factors in this case and the SG at paragraphs 50-56. She submitted that Dr Martinez Higueros has demonstrated a lack of insight. She had not apologised, nor accepted her mistakes. She failed to tell the truth during the hearing.

307. Having carried out an assessment of the aggravating and mitigating factors, Ms Barbour stated that the Tribunal must then turn to consider which sanction, if any, to impose. The Tribunal must start with the least onerous sanction.

Take no action

308. Ms Barbour stated that where a doctor's fitness to practise is impaired, it will usually be necessary to take action to protect the public (para 68), however there may be exceptional circumstances to justify a tribunal taking no action (para 70). She submitted that no such circumstances are present in this case.

Undertakings

309. Ms Barbour explained that no undertakings had been agreed, and they are therefore not available as a sanction for Dr Martinez Higueros. She said that, in any event this sanction would be unsuitable in this case.

Conditions

310. Ms Barbour stated that the purpose of conditions is to *'help the doctor to remedy any deficiencies in their practice, while protecting the public'* (paragraph 80). She said that conditions might be appropriate in cases involving a doctor's health, performance, or where a doctor lacks the necessary knowledge of English. She said that conditions are likely to be workable where a doctor has insight, and where a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings. A tribunal would have to be satisfied that a doctor would comply with any conditions. Ms Barbour said that, as this case involves dishonesty, then there are no conditions that could be deemed appropriate, and a more serious sanction is necessary.

Suspension

311. Ms Barbour addressed the Tribunal in relation to suspension. She said that 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 doctor. She said that suspension from the medical register also has a punitive effect although this is not its intention.

312. Ms Barbour said that suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration. Ms Barbour explained that suspension may be appropriate, for example, where there was acknowledgement of fault and where a tribunal is satisfied that the behaviour or incident is unlikely to be repeated.

313. Ms Barbour submitted that there has been no acknowledgment of fault in this case. She said that the denial of the facts (now found proved) should not be held against Dr Martinez Higueros as a separate aggravating factor. Nonetheless, the lack of an acknowledgment of fault is a factor which supports the submission that suspension would be inappropriate and insufficient to meet the overarching objective in this case.

314. Ms Barbour pointed out that the Tribunal has concluded that there is a risk of repetition, and there is limited evidence that Dr Martinez Higueros has taken steps to remediate her actions.

315. Ms Barbour referred to paragraph 97(a)-(g) which sets out factors where suspension may be appropriate. She said that the repeated dishonesty which compromised patient care and placed her own interests above those of patients was behaviour fundamentally incompatible with continued registration. She submitted that the other sub sections of paragraph 97 do not apply. There is very limited insight, and a risk of repeating behaviour. Ms Barbour submitted that Mr Morris could not rely on paragraph 97(f) because there had been another incident concerning Dr Martinez Higueros' probity.

Erasure

316. Ms Barbour addressed the Tribunal in relation to erasure and referred the Tribunal to paragraphs 107-111. She said that a well informed and reasonable member of the public would be shocked if the Tribunal drew back from imposing a sanction of erasure in this case.

317. Ms Barbour pointed out that the sanction of erasure is only available if it is the only means of protecting the public, which requires consideration of all 3 limbs of the overarching objective, including upholding standards and protection of public confidence. She said that erasure may be appropriate even where a doctor does not present a risk to patient safety,

when it is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

318. Ms Barbour asked the Tribunal to consider the factors set out at paragraph 109 which may indicate that erasure is appropriate. She said that there had been a particularly serious departure from the principles set out in GMP, and the behaviour is fundamentally incompatible with being a doctor. She submitted that Dr Martinez Higueros demonstrated a deliberate disregard for the principles set out in GMP and for patient safety. She said that there was a risk of harm to others - both colleagues and patients, and that Dr Martinez Higueros abused her position of trust. Dr Martinez Higueros was dishonest and placed her own interests before those of their patients. She had demonstrated a persistent lack of insight into the seriousness of her actions and the consequences of them for others.

319. Ms Barbour drew the Tribunal's attention to the SG section on dishonesty. It sets out that evidence of clinical competence cannot mitigate serious and/or persistent dishonesty. She pointed the Tribunal to paragraph 128, which states:

> *Dishonesty, if persistent and/or covered up is likely to result in erasure (see further guidance at paragraph 120–128).*

320. Ms Barbour reminded the Tribunal that it had also found serious misconduct in relation to clinical failures in relation to Patient A.

321. Ms Barbour summarised by stating that Dr Martinez Higueros' behaviour amounts to a number of serious breaches of GMP and demonstrates a wide ranging nature of the serious concerns. She submitted that the dishonesty, in a clinical setting, compromised patient care, was repeated, and is in conflict with the special position that Dr Martinez Higueros held as a doctor. It is fundamentally incompatible with registration. She submitted that the limited insight Dr Martinez Higueros has shown falls far short of what would be required to assuage the damage which these actions caused to public confidence in the profession.

Submissions on behalf of Dr Martinez Higueros

322. Mr Morris summited that an appropriate sanction in this case would be a period of suspension with a review at the end of the period. He recognised the inherent gravity of dishonesty, as set out in caselaw, but pointed out that there should be no automatic assumption of erasure. He said that dishonesty could differ in terms of nature and extent, and the Tribunal should work its way through the different sanctions in the SG, considering each in turn.

323. Mr Morris referred to paragraphs 24-25 of the SG, with regards to mitigating factors. He submitted that Dr Martinez Higueros has been of good character throughout her professional career in the UK, (5 ½ years) and there have been no other adverse regulatory findings against her. He submitted that these incidents of dishonesty were out of character and were somewhat isolated in both duration and range. He also asked the Tribunal to take into account the fact that 4 years has passed since these incidents took place.

324. Mr Morris then referred to the aggravating factors that needed to be considered and referred the Tribunal to paragraph 50 onwards. He accepted that there was a potential risk of harm to Patient A, and that Patient B's safety could have been compromised. There was a clear risk of harm to them. He accepted that another aggravating feature was the nature of Dr Martinez' rejected defence and the fact that, in Patient B's case, Dr Martinez-Higueros gave accounts in interview that could have affected her colleagues and called their probity into question.

325. Mr Morris also referred the Tribunal to paragraph 55(a)-(g) of the SG, which sets out examples of aggravating factors surrounding the circumstances of an event that are likely to lead a tribunal to consider taking more serious action. He accepted that paragraph 55(b) applied i.e. *'failure to work collaboratively with colleagues*'. He submitted that this is the only sub paragraph which is engaged in this case.

326. Mr Morris acknowledged that the Tribunal found that Dr Martinez Higueros has demonstrated limited insight. The Tribunal found that although she had, in general terms, addressed the potential impact of her actions and dishonesty on Patients A and B, the standing of her colleagues and the medical profession, she had not considered these issues in any detail.

327. With regards to remediation, Mr Morris acknowledged that taking remedial steps is inherent in demonstrating insight. He said that the GMC had raised a concern that Dr Martinez Higueros had failed *'to consult colleagues where appropriate*' (which is set out at paragraph 16(d) of GMP.) He said that there is evidence this has been remedied. He referred the Tribunal to the testimonials of Dr EA, who was Dr Martinez Higueros' appraiser for 2022 and 2023. He states:

> *'She showed proactive attitude towards…maintaining good communications with… colleagues.'*

328. He also pointed out the testimonial from Mr FA, consultant surgeon at Northampton general Hospital who states;

> *'She also performed well at …Multidisciplinary Meetings, Teaching and providing advice on radiological cases to other colleagues at different levels. … I personally had opportunity to discuss a good number of cases and planned vascular interventions in*

conjunction with her. I found Dr Martinez as a sincere, transparent and proactive professional… She …observed good communication within the team..'

329. Mr Morris also drew the Tribunal's attention to the 360 feedback from colleagues, which showed *'good'* or '*outstanding'* assessments in in '*Verbal Communication', 'Empathy and Respect',* and '*Team Player.'*

330. In relation to Dr Martinez Higueros' dishonesty, Mr Morris reminded the Tribunal that it accepted that the relevant courses she attended showed efforts on her part to remediate. He acknowledged, however, that the Tribunal found that she had provided no evidence as to what she had learned from those courses and what, if anything, she was now doing differently to prevent a similar situation arising again. He noted that the Tribunal concluded that there was only partial remediation. He submitted that Dr Martinez Higueros' failure to articulate any learning from her remedial courses does not mean that there was none.

331. Mr Morris noted that the Tribunal found that there is a remaining risk of repetition, but he asked that the seriousness of this risk should be judged in the context of the 4 years of continuing good character and absence of any adverse findings.

332. Mr Morris then asked the Tribunal to consider the paragraphs of the SG that relate to suspension. He referred firstly to paragraph 92, pointing out that suspension is appropriate where action must be taken to protect members of the public and maintain public confidence in the profession. He said that suspension is where the conduct of a doctor falls short of being fundamentally incompatible with continued registration. He submitted that Dr Martinez Higueros' good character demonstrates that this dishonesty was out of character and that she does not have any deep-seated attitudinal problem giving rise to a propensity to be dishonest.

333. Mr Morris directed the Tribunal's attention to paragraph 93. He submitted that Dr Martinez Higueros has taken some steps to mitigate her actions, although he accepted that the Tribunal found she has only achieved partial remediation and is not satisfied that the dishonesty is unlikely to be repeated. He noted the case of *Sawati,* (which was referred to at Stage 2), and submitted that ongoing denials were not a bar to insight and remediation.

334. Mr Morris referred to paragraph 97(a) - (g) which sets out a non-exhaustive list of factors that indicate suspension may be appropriate. He pointed out that the Tribunal did not conclude that there was evidence that further remediation is unlikely to be successful. He also said that is no evidence of similar behaviour since the incidents, and that there was some, albeit limited, insight. He noted that the Tribunal concluded that there is a remaining risk of repetition but pointed out that it had not characterised it as serious.

335. Mr Morris addressed the Tribunal in relation to erasure, because the GMC had submitted that it may be the appropriate course of action to take. Mr Morris accepted that

there are factors that point to erasure. He accepted that dishonesty is a deliberate disregard for principles set out in GMP, and that there had been abuse of trust. He also accepted that this was a case where putting a doctor's own interests before those of their patients applied.

336. Mr Morris submitted, however, that there were no attempts to cover up the dishonesty in Patient A's case. The addendum entry was not covered up in any way. The attempts to cover up the dishonest statements made in Patient B's case (during the interview with Dr F, the addendum entry and the email to the histopathology department) were '*doomed to fail*' because of documentary evidence listed at paragraphs 139-144 in the Determination on Facts. He said there were two episodes (once in Patient A's case and one assertion [left biopsy] in Patient B's case albeit repeated twice). He said that it was hard to say that on that basis Dr Martinez Higueros' actions were persistent dishonesty.

337. Mr Morris submitted that Dr Martinez Higueros has acknowledged the seriousness of the findings of the Tribunal. The fact that some of the erasure factors are present does not mean that Dr Martinez Higueros must be erased from the register. He referred the Tribunal to the cases of *Bawa-Garba v GMC* [2018] EWCA, *Civ* and *PSA v Health and Care Professions Council and Doree* [2017] EWCA Civ 319 at [26]. These cases confirm that the SG does not have statutory force, and that words in the SG such as *'may'* and '*indicate,'* show that it is permissive, not mandatory.

338. Mr Morris, submitted that, other than the clinical findings in this case, Dr Martinez Higueros remains a competent doctor. He directed the Tribunal's attention to the case of *Giele v GMC* [2005] *EWHC 2143 (Admin),* which states;

> *'… in considering maintenance of confidence, the existence of a public interest in not ending the career of a competent doctor will play a part.'*

339. Mr Morris submitted that, in all these circumstances, the overarching objective of securing patient safety and the wider public interest (upholding standards and maintaining public confidence) can safely be achieved by imposing a period of suspension. Erasure is unnecessary and disproportionate.

Relevant Legal Principles

340. The LQC gave advice at this stage, which is summarised below.

341. The Tribunal was advised that the decision as to the appropriate sanction, if any, is a matter for its own judgement, which must be made independently. The Tribunal must have regard to the SG (November 2020), which while not having statutory force, is a useful guidance and tool.

342. The Tribunal was reminded that it must consider the least restrictive sanction first, and then move on, if needs be, to consider the other available options in ascending severity.

343. The Tribunal should note that the decision on sanction is a balancing exercise-weighing up what is in the public interest, as against the interest of the Doctor. The Tribunal

must bear in mind that the purpose of a sanction is not to be punitive, but to protect patients and the wider public interest. Any sanction must be appropriate and proportionate, but the reputation of the profession as a whole is more important than the interests of any individual doctor.

344. The Tribunal should be mindful that Dr Martinez-Higueros is facing matters involving both clinical misjudgement, and dishonesty. Dishonesty lies at the top end of the spectrum of gravity of misconduct. There is no default rule, and so although erasure is often the outcome in dishonesty cases, it is not necessarily to be the case. Each case must be carefully considered by the Tribunal. It should look at the circumstances surrounding the events, whether the conduct is out of character, the extent of insight, and to what extent the reputation of the medical profession is affected.

345. At the beginning of stage 3, the Tribunal was informed by Ms Barbour of the following;

> *'Both parties agree that in paragraphs 25 and 28 of its determination on impairment, the Tribunal correctly reported an inaccurate submission made by Mr Morris: namely that no other concerns about Dr Martinez' probity had been raised. In fact, other concerns have been raised about her probity. No findings of fact have been made. You should not speculate about the other concerns raised. You should put from your mind the submissions made by defence counsel that no other concerns have been raised and should decide the appropriate sanction on the facts found proved and the information you have before you in the bundles and by way of live evidence. The submission that no previous regulatory findings have been made against Dr Martinez is correct'.*

346. The Tribunal was asked to follow the advice given in this Note. It should take into account the fact that Dr Martinez Higueros is of good character, in that she has no adverse regulatory findings against her before or since these incidents. It should put out of its mind, however, the submissions from Mr Morris that no other concerns have been raised.

347. The Tribunal was also told that the witnesses who had given references and testimonials on behalf of Dr Martinez-Higueros had not been made aware of the other concerns that have been raised about her probity. The Tribunal was reminded that it was a matter for it as to what weight, if any, it places on the testimonials and other material produced by the defence at the impairment stage.

348. The Tribunal will be aware this stage of the overarching objective of the GMC set out in section 1 of the Medical Act 1983 (as amended) which requires the Tribunal to:

a. Protect, promote, and maintain the health, safety, and well-being of the public,

b. Promote and maintain public confidence in the medical profession, and

c. Promote and maintain proper professional standards and conduct for members of that profession.

The Tribunal's Determination on Sanction

349. In reaching its decision, the Tribunal first identified what it considered to be the mitigating and aggravating factors in this case.

Mitigating Factors

350. The Tribunal noted that this was a serious case regarding dishonesty in clinical settings involving two patients, which caused a risk to their safety. Consequently it felt less able to take mitigating factors into account, but nevertheless considered them carefully. The Tribunal referred to paragraphs 24-49 of the SG and considered the following to be mitigating factors in this case.

351. The Tribunal noted that Dr Martinez Higueros has been a qualified doctor since 2008 and is now an experienced consultant radiologist. She is of previous good character, in that there had been no adverse regulatory findings against her. The Tribunal noted that, save for the clinical failings in this case, she appears to be a competent doctor with good technical skills, and it noted the logbooks demonstrating the number of procedures she has carried out. However, the Tribunal gave her experience and competency limited weight as this is a case involving serious dishonesty.

352. The Tribunal has been provided with a number of positive testimonials in support of Dr Martinez Higueros. They were taken into account during Stage 1 and 2 of the hearing. However, the Tribunal was informed by the parties that other concerns have been raised about Dr Martinez Higueros' probity. While the Tribunal did not take those new concerns into account when making its decision on sanction, it was informed that those providing testimonials were not aware of the new concerns when making their statements. The Tribunal still took these statements into account, but adjusted the weight they could now attribute to them. It noted that they were positive, in terms of both Dr Martinez Higueros' clinical ability and probity. The Tribunal also took into account the positive 360 degree appraisal feedback from both patients and colleagues, and the '*good*' and '*outstanding*' markings under all competencies. These showed that there was evidence she could work collaboratively with colleagues.

353. The Tribunal noted that there had been a lapse of time (4 years) since the incidents occurred.

354. The Tribunal acknowledged the courses that Dr Martinez Higueros attended which showed some attempts at remediation.

Aggravating factors

355. The Tribunal referred to paragraphs 50-55 of the SG and considered the below to be the aggravating factors in this case.

356. The Tribunal was mindful that this was a case of dishonesty in a clinical setting. Dr Martinez Higueros' dishonesty compromised the safety of 2 patients, and patient B had to undergo a second biopsy. She had called the capability and probity of fellow professionals into question and Dr L, a junior doctor, could have been unfairly criticised if Dr Martinez Higueros' account had been believed. This showed a failure to work collaboratively with colleagues and a disregard for patient safety.

357. The Tribunal acknowledged that Dr Martinez Higueros was entitled to defend herself but noted that she had given varying accounts of her actions in the face of a compelling body of oral, written and contemporaneous evidence to the contrary. It determined that she failed to tell the truth during the hearing.

358. The Tribunal was concerned that, notwithstanding the incidents took place 4 years ago, it had minimal evidence that Dr Martinez Higueros has developed insight into her misconduct. Dr Martinez Higueros had provided a reflective statement, but the Tribunal did not have evidence that she understood the gravity of her dishonesty and the impact of her actions on patients and colleagues The Tribunal determined that there was no timely development of insight, and it was limited and generalised in nature.

359. The Tribunal noted that Dr Martinez Higueros has not offered an apology to either Patient A or B, nor the fellow professionals impacted by her actions. It determined that she had abused the trust that patients, colleagues and the public would have in a doctor.

360. The Tribunal accepted that Dr Martinez Higueros had attended some relevant courses but remained concerned that she had not provided any evidence as to what she had learned from those courses and what, if anything, she was now doing differently to prevent a similar situation arising again.

361. The Tribunal then moved on to deciding on sanction, considering the least restrictive first.

No action

362. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Martinez Higueros's case, the Tribunal first considered whether to take no action, and noted paragraph 68-70 of the SG. It decided that there were no exceptional circumstances in this case that could justify taking no action. It was satisfied that to take no action would not be

appropriate or proportionate given the serious nature of its findings and it would fail to uphold the statutory overarching objective.

Conditions

363. The Tribunal next considered whether it would be appropriate to impose conditions on Dr Martinez Higueros' registration. It considered paragraph 81 and 82 of the SG. It noted that conditions are likely to be appropriate in cases involving the doctor's health, performance, or lack of knowledge of the English language. The Tribunal decided that these factors were not applicable in this case.

364. The Tribunal also noted that any conditions must be workable and measurable. The Tribunal was not satisfied that Dr Martinez Higueros has demonstrated sufficient insight and did not consider it possible to formulate appropriate conditions to address the concerns in this case.

365. In any event, in considering the need to uphold the overarching objective, the Tribunal was of the view that imposing conditions on Dr Martinez Higueros registration would not sufficiently mark the seriousness of this case. Conditions would not be appropriate as they would not be sufficient to maintain public confidence in the profession and uphold proper professional standards. The Tribunal was therefore satisfied that the imposition of conditions would not be an appropriate response in this case.

Suspension

366. The Tribunal went on to carefully consider whether to impose a period of suspension on Dr Martinez Higueros' registration. The Tribunal noted firstly that suspension as a sanction has a deterrent effect and can be used to send out a signal to both the doctor and the public. It then took into account paragraphs 92 and 93 of the SG which state;

> ***92*** *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*
>
> ***93*** *Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions…*

367. The Tribunal considered the factors listed at paragraphs 97(a)-(g) of the SG, where suspension may be deemed appropriate. It accepted that there were some factors that applied in this case. For example, there was no evidence of repetition of similar behaviour since the incident, and there was some, albeit limited insight and attempts at remediation. However, the Tribunal decided that there had been a series of serious breaches of GMP and felt that the misconduct was fundamentally incompatible with Dr Martinez Higueros' continued registration.

368. In any event, in considering the need to uphold the overarching objective, the Tribunal determined that a period of suspension would not be sufficient to maintain public confidence in the profession and promote and maintain proper professional standards and conduct for members of the profession.

Erasure

369. The Tribunal went on to consider whether erasure would be an appropriate sanction. The Tribunal took into account paragraph 108 which states;

> *'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*

370. The Tribunal decided that there remains a risk to patient safety in this case. There were clinical failures that amounted to serious misconduct and serious dishonesty.

371. The Tribunal went onto consider paragraph 109 which sets out a non-exhaustive list of factors that, if present may indicate erasure is appropriate. The Tribunal decided that the following factors were present in Dr Martinez Higueros' case:

> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*
>
> *c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 129–132 regarding failure to provide an acceptable level of treatment or care).'*

d Abuse of position/trust (see Good medical practice, paragraph 81: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').

372. The Tribunal determined that Dr Martinez Higueros' misconduct amounts to a series of significant departures from GMP, and that she displayed a deliberate disregard for patient safety, considering her own interests above theirs. There was a risk to the safety of Patients A and B, and a potential impact on fellow professionals. The Tribunal concluded that Dr Martinez Higueros abused the trust that patients, colleagues, and the public had placed in her.

373. The Tribunal considered the dishonesty in this case and noted that it involved amending patient records. It also had regard to paragraph 128 of the SG which states that '*dishonesty, if persistent and/or covered up, is likely to result in erasure.'* The Tribunal noted that there were 2 instances of dishonesty that took place in a short period of time and involved 2 separate patients. Dr Martinez Higueros used her dishonesty in attempts to cover up her clinical failings. The Tribunal was satisfied that the nature of this misconduct is fundamentally incompatible with continued registration.

374. The Tribunal determined that, having found Dr Martinez Higueros to have acted dishonestly, coupled with clinical failings, erasing Dr Martinez Higueros' name from the medical register was the only appropriate sanction in this case. While it bore in mind the impact that such a sanction would have on her, the Tribunal determined that erasure was necessary to protect patients, uphold confidence in the medical profession and maintain proper professional standards. Also, the Tribunal decided that erasure was necessary to maintain public confidence in the profession. It was of the view that a member of the public would be concerned if a sanction of erasure were not imposed.

DETERMINATION ON IMMEDIATE ORDER - 19/04/24

375. Having determined that Dr Martinez Higueros name be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Martinez Higueros registration should be subject to an immediate order.

Submissions

376. On behalf of the GMC, Ms Barbour, Counsel, submitted that an immediate order was necessary in this case. She referred the Tribunal to the relevant paragraphs of the SG and submitted that, given the circumstances of this case, an immediate order of suspension would uphold the public's confidence in the profession.

377. She further submitted that the Interim order should remain in place as there are other fitness to practise matters outstanding.

378. On behalf of Dr Martinez Higueros, Mr Morris made no submissions on the matter.

The Tribunal's Determination

379. The Tribunal has taken account of the relevant paragraphs of the SG, in particular paragraphs 172, 173 and 178 as set out below:

> *172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, … where immediate action must be taken to protect public confidence in the medical profession.*
>
> ……..
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.*

380. In reaching its determination, the Tribunal considered the submissions of GMC Counsel, the facts previously found proved, and the relevant paragraphs of the SG.

381. The Tribunal reminded itself of its findings as to the seriousness of Dr Martinez Higueros' misconduct and its determination on impairment and sanction, noting its decision that Dr Martinez Higueros' name should be erased from the register to uphold all three limbs of the overarching objective.

382. The Tribunal concluded that it would be inappropriate not to impose an immediate order in this case, given its finding of serious misconduct. The Tribunal found that the misconduct in this case was so serious that the only appropriate sanction was that of erasure, and that a risk of repetition remained.

383. The Tribunal determined that public confidence in the profession would be undermined and that it would be failing to uphold the statutory overarching objective if an immediate order were not imposed in this case.

384. Accordingly, the Tribunal determined that an immediate order of suspension was required in the public interest.

385. This means that Dr Martinez Higueros' registration will be suspended from today. The substantive direction will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

386. That concludes this case.