PUBLIC RECORD

Dates: 06/08/2024 - 07/08/2024

Medical Practitioner's name:	Dr Miguel NADAL
GMC reference number:	2593034
Primary medical qualification:	MB BS 1982 University of London

Type of case

Review - Misconduct

Outcome on impairment

Not Impaired

Summary of outcome

Suspension to expire

Tribunal:

Legally Qualified Chair	Mr Lee Davies
Lay Tribunal Member:	Mrs Lorna Taylor
Medical Tribunal Member:	Dr Becky McGee

Tribunal Clerk:	Mrs Anne Bhatti

Attendance and Representation:

Medical Practitioner:	Present, not represented
GMC Representative:	Ms Frances Connor, Counsel

Attendance of Press / Public

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

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 Impairment - 07/08/2024

1. At this review hearing 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 Nadal's fitness to practise is impaired by reason of misconduct.

Background

2. Dr Nadal qualified in as a doctor and had full registration with the GMC in 1983. In 1987, Dr Nadal set up his own medical assistance company, Lifeline PLC and was a director of this company. Lifeline provided an advisory service to travel insurance companies who insure travellers from the United Kingdom (UK). Dr Nadal whose role was described as an 'Assistance Medic' was employed/engaged by insurance companies to advise as to whether an insured person was covered for medical treatment under the terms of their travel insurance policy. In particular, in the context of this case, he also provided advice to the insurance company as to whether an insured who has become unwell abroad should be repatriated home to the UK by air ambulance for treatment and care.

3. Since 2011, Dr Nadal had been the Medical Director of Travel Insurance Facilities' ('TIF') assistance service, Emergency Assistance Facilities ('EAF'). Dr Nadal was not employed by TIF but engaged through his company, Lifeline. The Medical Team, which Dr Nadal led, advised TIF on medical matters relating to insured UK travellers, specifically on if, when and how to transfer people who have become unwell abroad. TIF, EAF, Lifeline, and by extension Dr Nadal, did not advise or take responsibility for decisions on, or the provision of, treatment to the insured. This responsibility remained with the medical professionals who were, at the relevant time, providing treatment and care to the insured as their patient. These would usually be, and were in these cases, the doctors who were treating the insured at a hospital in the host country.

2023 Tribunal

4. The facts found proved at Dr Nadal's hearing which took place in July 2023 ('2023 Tribunal') related to two travel insurance policyholders in respect of whom repatriation was sought under the terms of their policies following them having become unwell whilst abroad. Although Dr Nadal was the Medical Director of EAF's Medical Team and had some responsibility for others in the team, the Allegation had not related to any alleged failures by Dr Nadal in any supervisory capacity. Rather, the Allegation had related to his personal involvement in the advice and decision-making acting on behalf of EAF.

5. In each case, the patient died within weeks of being taken ill (Patient B died before being repatriated, Patient D died shortly after being repatriated to the UK by air ambulance as arranged by his family). The GMC did not allege that the insurer's refusal to repatriate Patient B or Patient D on the advice of Dr Nadal, caused or contributed to their deaths. Neither was it alleged that the decision not to repatriate was necessarily the wrong decision in the circumstances.

6. The 2023 Tribunal found that that in relation to Patient B, the decisions not to repatriate were inadequate due to Dr Nadal's failures: in monitoring treatment and progress at the host hospital; discussing the case with Patient B's UK Consultant Haematologist ('Dr C') to utilise specialist advice being offered to him; pursing early aeromedical repatriation having regard to Patient B having a condition that required specialist care and the necessary clinical expertise on Patient B's conditions not being available at the host hospital. Furthermore the Tribunal found that Dr Nadal's communication with Patient B's family was inappropriate in that Dr Nadal shared an unprofessional opinion about Dr C's letter and the ability of Worthing Hospital to manage Patient B's condition effectively.

7. The 2023 Tribunal found that in relation to Patient D, Dr Nadal's communication with Patient D's family was inappropriate in that Dr Nadal justified why air transfer to the UK was not possible by giving irrelevant, unsubstantiated and / or exaggerated risks regarding the air environment; provided his personal political views on healthcare within the EU and the UK which had no relevance to Patient D's care; made disparaging remarks about the input of Consular staff and knowledge of aviation medicine of specific nationalities; mentioned other cases of repatriation in which the patient died; and stated that the UK government delayed issuing Provisional Replacement Certificate to reduce costs.

Impairment

8. The 2023 Tribunal concluded to find misconduct which was serious in relation to Dr Nadal's inadequate decision making in respect of Patient B. It did not find misconduct which was serious in relation to Dr Nadal's communication with Patient B's family member, because Dr Nadal had not caused the family member additional distress and in the 2023 Tribunal's view were not intended to cause offence.

9. In relation to Dr Nadal's communication with Patient D's family being inappropriate with regards to his comments justifying why air transfer to the UK was not possible by giving irrelevant, unsubstantiated and/or exaggerated risks regarding the air environment. The 2023 Tribunal concluded that this amounted to misconduct which was serious because they had been grossly insensitive and were apt to mislead Patient D's family member who was already highly distressed. Furthermore, it also found the misconduct was serious in relation to the comments made by Dr Nadal about other cases of repatriation in which the patient died, the reasoning was because of its obvious potential to cause the family member further distress.

10. The 2023 Tribunal did not find misconduct which was serious in relation to Dr Nadal's comments about his political views about healthcare within the EU and UK, disparaging remarks about the input of Consular staff and knowledge of aviation medicine of specific nationalities; stated delays for cardiac intervention in the UK were the worst in Europe; stated that the UK government delayed issuing Provisional Replacement Certificate to reduce costs. The 2023 Tribunal had found that Dr Nadal's inappropriate comments had ranged from being irrelevant and unhelpful to absurd and disparaging. It considered that whilst the comments made were misguided, they did not of themselves amount to serious misconduct.

11. The 2023 Tribunal had identified serious misconduct in two distinct areas, in Dr Nadal's inadequate decision-making in respect of Patient B, and his inappropriate communications with Patient D's family member regarding the risks of the air environment and his comments about other cases of repatriation where the patient had died. The Tribunal concluded that Dr Nadal's failings in respect of Patient B amounted to serious and significant breaches of GMP. In addition, his communications with Patient D's family member represented further serious breaches. The 2023 Tribunal found that Dr Nadal's failings in both respects, and particularly regarding his failings regarding Patient B, would be considered deplorable by fellow members of the medical profession.

Accordingly, the 2023 Tribunal concluded that Dr Nadal's conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct that was serious.

12. The 2023 Tribunal was satisfied that the apologies and remorse set out in Dr Nadal's written reflections were heartfelt and genuine. Dr Nadal had accepted that he failed in his handling of Patient B's case, and he had acknowledged that his inappropriate communications had the potential to upset and heighten the distress of the families of both Patient B and Patient D. Dr Nadal recognised the impact of his actions and had accepted that his failings impact on public trust in him and in the wider profession. However, Dr Nadal was yet to develop full insight because he did not appear to properly understand and appreciate that, in respect of Patient B, a policyholder with a deteriorating life-threatening condition, Dr Nadal was a registered medical practitioner who was in a position to facilitate Patient B receiving necessary treatment and care.

13. The 2023 Tribunal considered that for Dr Nadal to successfully remediate his misconduct, he would first need to develop full insight, only then could he take meaningful steps to address the specific failings identified in his decision-making and communication skills.

14. In respect of his inadequate decision-making regarding Patient B, the Tribunal determined that there remained a risk. In respect of Dr Nadal's failures in communication, the Tribunal accepted that he had recognised in his reflective statement that his communications that contributed to the stress of Patient D's relatives. Nonetheless in the absence of remediation of his communication failures, the risk of repetition remained.

15. The 2023 Tribunal found that in respect of Dr Nadal's inappropriate communication with Patient D's family member, a finding of impairment was necessary given the risk of repetition, to protect patients and uphold the public interest.

16. With regards to the Dr Nadal's failings in respect of decision-making in Patient B's case the 2023 Tribunal found his failings with regard to Patient B's case were significant and substantial, they spanned a number of days, and had the very real potential to cause grave harm. The 2023 Tribunal determined that a finding of impairment was necessary to uphold all three limbs of the overarching objective.

Sanction

17. The 2023 Tribunal was satisfied that, with full knowledge of the facts, context and current situation faced by Dr Nadal, the public interest would be satisfied by a period of suspension. The Tribunal had concluded that Dr Nadal's insight was developing and it had found that Dr Nadal had begun to reflect on and understand the impact of his actions in terms of his communications on the families of Patient B and Patient D. Whilst his insight was only developing, Dr Nadal had demonstrated a willingness to continue to develop his insight with time.

18. The Tribunal determined to suspend Dr Nadal's registration from the medical register for a period of 12 months. The Tribunal considered that only imposing the maximum period of suspension would adequately mark the seriousness of Dr Nadal's proven misconduct, meet the public interest in maintaining confidence in the profession and upholding professional standards. Further, the Tribunal was of the view that if Dr Nadal is to properly develop insight into and remediate his misconduct, he will need enough time to explore and address the entrenched thinking and communication styles that contributed to the failings identified by the Tribunal.

19. The Tribunal determined to direct a review of Dr Nadal's case. A review hearing will convene shortly before the end of the period of suspension. At the review hearing, the onus will be on Dr Nadal to demonstrate to the reviewing Tribunal that he has reflected on and developed further insight into his misconduct, taken appropriate steps towards remediation and kept his skills and knowledge up to date.

20. The Tribunal acknowledged that it is unlikely that Dr Nadal will pursue medical practice in the future. As it had previously observed, if Dr Nadal does not wish to remain on the medical register, it is open to him to apply for VE at any time now that these proceedings have concluded with a finding of impairment and the imposition of a sanction.

The Evidence

21. The Tribunal has taken into account all the evidence received, both oral and documentary.

22. Dr Nadal provided his own reflective statement dated 15 July 2024 and also gave oral evidence at the hearing.

Dr Nadal

23. XXX. Dr Nadal agreed that that his failings were serious in relation to Patient B and D. In oral evidence he mentioned that he did not have some of the background as to what was happening with Patient B at the time of the incident, until he had received the bundle from the GMC for the 2023 Tribunal hearing. He had fully accepted that he should have done more with Patient B and should have done more in considering the case and transferred his focus to Patient B. However at the time his focus was more on other cases. At the time the insurer's workload had expanded and therefore there had been more requests for air ambulances than ever before. Dr Nadal had realised he should have priorotised Patient B's case. He stated that he had insight after speaking to Patient B's family member and he would have had more awareness if he had spoken to the family member earlier.

24. Dr Nadal stated that in relation to Patient B, he could have made further enquires and reviewed the medical notes and he could have gone to the insurers and advised an air ambulance was required. Patient B's case caused him deep concern. Dr Nadal had reflected that Patient B was put through hell and tremendous suffering. He stated he should have focused on Patient B and should have spoken to the family directly. He had his priorities the wrong way round and he very much regretted that. Dr Nadal stated that the GMC were correct regarding his failure to speak to Dr C. He accepted that Good Medical Practice ('GMP') required him to do more than he did. He should have spoken to Patient B's family member and should have done more to help organise the appropriate treatment.

25. Dr Nadal stated that he had spoken to senior lawyers and he had been advised that he had no direct duty to the insured but he had a duty to get it right. He stated that he had a duty under GMP because he had breached GMP. He stated that GMP required him to do more. He understood that acting the way he did breached GMP. He stated that he could not have a duty to two masters and recognised that and had thought about it since. He had spent a considerable amount of time thinking what he should have done and who he should have spoken to, for example, the doctor in the University Hospital. Dr Nadal stated that he had considered what might work and about extracting Patient B from the clinic to have him transferred elsewhere. Dr Nadal accepted he did not do as much as he could have.

26. Dr Nadal explained to the Tribunal that he had been working seven days a week, 16 hours a day at the time. He had been distracted and that resulted in nice decent people being affected. He had gotten his priorities wrong. He felt he had let himself down and stated that he was scared after having previous proceedings brought against him, albeit there were no adverse findings, save for a breach of confidentiality, which led to no finding of impairment. He had allowed fear to impact his judgement, whilst Patient B and D were not his patients he felt like they were.

27. Dr Nadal accepted that the words he had used during his communication were possibly over emphatic and appeared disrespectful. He said he did not mean to denigrate Worthing Hospital. This hospital had looked after Patient B really well and they had sent Patient B to St Bartholomew's Hospital appropriately when more specialist care was required. Dr Nadal said that the way he worded things, intelligent people misinterpreted him. He stated that he could have communicated in a more sensitive, effective, intelligent manner and he gave an example of how he would have done this. He stated that it would have been more effective to put Worthing Hospital and the treatment Patient B had received there in a positive light. He had needed a lot more thought and should have spoken to Patient B's family member. He stated that he had insight into his failings.

28. Dr Nadal acknowledged in response to questions from the Tribunal that public confidence in the profession had been damaged by his actions. He highlighted that his substantive hearing had attracted significant media coverage. Dr Nadal's family had been embarrassed and his reputation had been damaged with the findings of impairment from the previous Tribunal. In terms of his future plans, Dr Nadal stated that he had no intention of returning to practise as he had retired.

29. The Tribunal received the following documentary evidence which included and was not limited to:

    - Record of determination dated 26 July 2023;
    - Correspondence between Dr Nadal and the GMC, various dates;
    - Dr Nadal's reflective statement dated 15 July 2024.

Submissions

On behalf of the GMC

30. On behalf of the GMC, Ms Frances Connor submitted Dr Nadal had reflected on the previous misconduct. He had indicated in his evidence that he should not have been so constrained by insurers wishes not to speak to people, and it would have been worthwhile speaking to Patient B's family member. He indicated that had he spoken to Patient B's family member, he would have been better advised about the circumstances faced by Patient B and had he appreciated the full circumstances he would have been able to re-engage the insurer. Likewise had he engaged with Dr C, he again would have been better advised and informed about the circumstances and would have put in place a plan to break the stalemate, that Patient B had found himself in through no fault of his own.

31. Dr Nadal had accepted that had he done those things, then he would have put in place the plan at an earlier stage. On reflection he had accepted that had he more sight of the notes then he may have appreciated at an earlier stage the circumstances that Patient B found himself in, and also would have caused him to take action earlier. He accepted that he should have done more sooner and expressed that he did not do so. He had expressed regret. Dr Nadal repeated again that, had he communicated effectively with the family and with Dr C, he would have appreciated the circumstances and taken steps to re-engage the insurer. Dr Nadal accepted that he did not prioritise properly and again, that he should not have been so constrained by the insurers wishes.

32. Dr Nadal accepted in oral evidence that GMP required him to do more than he did and communicate more with the Patient B's family and Patient B's doctor as a possible route. He mentioned that with hindsight he could have contacted the University Hospital, Aydin and expressed views and try to persuade them to collect Patient B.

33. In relation to Patient D, Ms Connor as she had done when opening the case submitted on behalf of the GMC that Dr Nadal had fully reflected upon his failings in that case, by virtue of his reflective statement dated 15 July 2024.

34. Ms Connor submitted that in all of the circumstances, the GMC's position in respect of impairment for the original misconduct remained neutral. However, in respect of impairment on the grounds that Dr Nadal had been out of clinical practice for an

extended period of time, as accepted by Dr Nadal, that the GMC's position was that his fitness to practise remained impaired.

Dr Nadal

35. Dr Nadal submitted that prior to the events leading to this hearing he had a faultless career. He had been before the MPTS for previous matter prior to the 2023 Tribunal and had been vindicated, and therefore had a a clear record. His problems started after the death of a close family member and so then his problems had arisen very much as a consequence of not just being a doctor, but trying to assist insurers in circumstances where normally he would not. He submitted that it would never happen again because he had finished. He submitted that he understood the failings and GMC findings and genuinely regretted them.

36. Dr Nadal submitted that he had handled thousands of cases between 2018 and 2022, without complaint. He submitted that in very few of them did he speak directly to people, but certainly he was involved and assisted in many cases. So he did not see himself as being impaired. He submitted that his suspension should be lifted.

37. Dr Nadal submitted that he certainly would not try to retrieve a licence to practise. He had demonstrated between 2010/2012 to 2016 that he had done his work advising insurers without a licence to practise. He submitted that it was an honour to be a member of the medical profession and he would like to have the suspension lifted and then after a short while, when people can see that he had joined the medical register he will then retire. He submitted in the long term, he would not maintain registration because it served no purpose.

38. Dr Nadal submitted that he had learnt from the complaints that were already in his possession and changed how he had worked. He submitted that he had remediated the serious misconduct. He wanted to concentrate on his family life going forward.

The Relevant Legal Principles

39. The Tribunal reminded itself that the decision of impairment is a matter for the Tribunal's judgement alone. As noted above, the previous Tribunal set out the matters that a future Tribunal may be assisted by. This Tribunal is aware that it is for the doctor to satisfy it that he would be safe to return to unrestricted practice.

40. This Tribunal must determine whether Dr Nadal's fitness to practise is impaired today, taking into account Dr Nadal's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

41. This is borne out by the case of *Khan v General Pharmaceutical Council [2016] UKSC 64* where the Supreme Court stated that the focus of a review hearing is upon the current fitness of the doctor to resume practice, judged in light of what they have achieved since the last hearing. The question is does their fitness to practise remain impaired.

42. When considering impairment, the Tribunal must do so set against the overarching objective of public protection and whether all or any of the three limbs are engaged.

The Tribunal's Determination on Impairment

43. The Tribunal considered whether Dr Nadal's fitness to practise is currently impaired in relation to the misconduct.

44. The Tribunal had before it, Dr Nadal's reflective statement dated 15 July 2024 and took into consideration Dr Nadal's oral evidence at the hearing. The Tribunal bore in mind that Dr Nadal chose to give oral evidence at the hearing and by giving oral evidence he had opened himself up to cross examination by the GMC and Tribunal questions. When Dr Nadal gave his oral evidence, he had answered every question, which was put to him by both the GMC counsel and the Tribunal. The Tribunal was of the view that whilst Dr Nadal's communication style when giving oral evidence was very detailed and he had gone off topic at times, he was not an expert on giving oral evidence or an expert witness.

45. In the Tribunal's assessment he had tried his best to help the Tribunal understand the background rather than try to mislead it. When Dr Nadal gave oral evidence, it initially appeared that Dr Nadal had not accepted some of the findings of the 2023 Tribunal, however later in his oral evidence Dr Nadal was specific and clear that he did accept the findings of the 2023 Tribunal, however had not accepted the context around some of the findings. It was clear to the Tribunal that he had now accepted all of the Allegation that had been found proven against him. The Tribunal concluded that Dr Nadal's evidence was credible.

46. The Tribunal bore in mind that Dr Nadal did not intend to return to working as a doctor. The Tribunal was of the view that Dr Nadal had considered the impact of the misconduct and had related that to what he could do in the future and how he would act differently for example changing his communication style. The Tribunal accepted Dr Nadal's evidence that he had learnt from his past failings and would not repeat them. Furthermore, the Tribunal accepted that Dr Nadal had no intention to return to medical practice at this time.

47. Dr Nadal had understood the impact of public confidence in the medical profession and the impact on his reputation as a doctor. The Tribunal bore in mind that the misconduct found proven was very specific to the unusual facts of the case. Dr Nadal had explained to the Tribunal that he would not act in the same way in the future and had demonstrated he understood where he had gone wrong. Dr Nadal stated in oral evidence that he had got the assessment of priorities wrong. He had been dealing with so many incidents and had identified this and that he should have prioritised Patient B's case. The Tribunal determined that this was insightful of Dr Nadal to recognise. Dr Nadal had been candid in his oral evidence and did state that there had been a conflict between insurer and patient and that he had taken the wrong turn.

48. The Tribunal bore in mind that Dr Nadal was genuinely remorseful and upset by what had happened to Patient B. The Tribunal took into consideration that the GMC accepted that Dr Nadal had full insight in relation to the misconduct with regards to Patient D. The Tribunal accepted the GMC's stance that having considered Dr Nadal's reflective statement that he had shown full insight in relation to Patient D. The Tribunal concluded to find sufficient insight for the misconduct which included both his decision-making skills and communication skills.

49. The Tribunal determined that there was no risk of repetition of Dr Nadal repeating the misconduct due to his sufficient insight and there had been no repetition of his behaviour since. It bore in mind that Dr Nadal had not intended to practise as a doctor and planned on retiring. The Tribunal was of the view that he was safe to resume unrestricted practice because there was no risk of repetition. At present Dr Nadal did not have a licence to practise and should he wish to apply for a licence to practise he would have to go through a process of revalidation, which included ensuring his medical knowledge and skills are up to date.

50. The Tribunal was of the view that a finding of impairment was not necessary to uphold all three limbs of the overarching objective. There was no longer a risk of repetition and therefore there was no longer a requirement to make a finding of impairment to protect the public. Furthermore, there was no longer a requirement to make a finding of impairment to promote and maintain public confidence in the medical profession and proper professional standards and conduct for members of that profession because Dr Nadal had sufficient insight and had remediated to the extent he could. The public interest had been marked by Dr Nadal having been suspended from the Medical Register.

51. This Tribunal has therefore determined that Dr Nadal's fitness to practise is not impaired by reason of misconduct.

52. The Tribunal bore in mind that the currently imposed order of suspension is due to expire on 30 August 2024. The Tribunal was of the view that with reference to its findings and the overarching objective, it would be in in the public interest for the current suspension to continue until the date it expires.

53. That concludes the case.