PUBLIC RECORD

Dates: 06/09/2021 – 15/10/2021;
04/07/2022 – 26/07/2022;
21/02/2023 – 10/03/2023;
27/03/2023 – 29/03/2023;
22/04/2023 – 23/04/2023;
18/07/2023 – 26/07/2023

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

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

Summary of outcome
Suspension, 12 months
Review hearing directed

Tribunal:

Legally Qualified Chair	Mr Tim Bradbury
Lay Tribunal Member:	Mr Geoff Brighton
Medical Tribunal Member:	Dr Thomas George

Tribunal Clerk:	Mr Michael Murphy (06/09/2021 – 15/10/2021) Ms Evelyn Kramer (04/07/2022-26/07/2022; 21/02/2023 – 10/03/2023; 27/03/2023 – 29/03/2023; 22/04/2023 – 23/04/2023; 18/07/2023 – 26/07/2023)

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr William Edis QC (until 25/07/2022), instructed by: Viridian Law (06/09/2021 – 15/10/2022 DAC Beachcroft (04/07/2022 – 25/07/2022) Mr Christopher Geering, Counsel from 21/02/2023, instructed by DAC Beachcroft
GMC Representative:	Ms Susanna Kitzing, 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 Facts - 23/04/2023

Background

1. Dr Nadal qualified 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 remains the director.

Lifeline provides an advisory service to travel insurance companies who insure travellers from the United Kingdom (UK). Dr Nadal has considerable experience within the repatriation and travel insurance industry. Dr Nadal whose role is described as an 'Assistance Medic' is employed/engaged by insurance companies to advise as to whether an insured person is covered for medical treatment under the terms of their travel insurance policy. In particular, in the context of this case, he also provides 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.

2. Since 2011, Dr Nadal has been the Medical Director of Travel Insurance Facilities' ('TIF') assistance service, Emergency Assistance Facilities ('EAF'). Dr Nadal is not employed by TIF but engaged through his company, Lifeline. The Medical Team, which Dr Nadal leads, advises TIF on medical matters relating to insured UK travellers, specifically on if, when and how to transfer people who have become unwell abroad. It is important to record that TIF, EAF, Lifeline, and by extension Dr Nadal, do not advise or take responsibility for decisions on, or the provision of, treatment to the insured. This responsibility remains with the medical professionals who are, at the relevant time, providing treatment and care to the insured as their patient. Those will usually be, and were in these cases, the doctors who were treating the insured at a hospital in the host country.

3. The Allegation against Dr Nadal relates to three travel insurance policyholders in respect of whom repatriation was sought under the terms of their policies following their 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 does not relate to any alleged failures by Dr Nadal in any supervisory capacity. Rather, the Allegation relates to his personal involvement in the advice and decision-making acting on behalf of EAF.

4. In each case, the patient died within weeks of being taken ill (Patient A and 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 do not allege that the insurer's refusal to repatriate Patient A, Patient B or Patient D on the advice of Dr Nadal, caused or contributed to their deaths. Neither is it alleged that the decision not to repatriate was necessarily the wrong decision in the circumstances.

5. However, it is alleged that, in relation to all three patients, the decisions not to repatriate were inadequate due to numerous failures in the obtaining and/or ascertaining of

relevant information in order for an informed and adequate assessment of the relative risks and/or benefits as between repatriation to the UK or the patients remaining in the host country for treatment. It is alleged that the relevant information was either not sought at all or was not sought when it ought to have been. Further, it is alleged in relation to communications between Dr Nadal and the families of both Patient B and Patient D, and Ms E, a Consular Officer involved in Patient D's case, that Dr Nadal's communications were on occasions inappropriate and unprofessional.

6. The initial concerns were raised with the GMC in June 2018 by Ms D, Patient D's daughter.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the stem of paragraph 2 of the Allegation to standardise the anonymisation of Patient B. Mr Edis QC, on behalf of Dr Nadal did not oppose this application.

8. The Tribunal granted the GMC's application for Dr C to remain anonymised. On behalf of the GMC, Ms Kitzing submitted that if Dr C was not anonymised, he may be subject to criticism. She also submitted that Dr C has a right not to incriminate himself. On behalf of Dr Nadal, Mr Edis submitted that Dr C's name is already in the public domain as he has been referred to during these proceedings. The Tribunal did not accept that because Dr C's name has been mentioned previously it should be mentioned again. It determined that Dr C's name should be anonymised in any transcript or determination to prevent any unnecessary dissemination of matters critical of him and to which he did not have an opportunity to respond.

9. The Tribunal refused the GMC's application, made pursuant to Rule 34, for the evidence of Dr I to be admitted. The Tribunal's full written determination is included at Annex A.

10. Having concluded that there was insufficient time to conclude the case, the Tribunal determined to adjourn the hearing part heard and issue case management directions. The Tribunal's decision on adjournment and its directions for parties is included at Annex B.

11. The Tribunal granted, in part, the application made on behalf of Dr Nadal under Rule 17(2)(g) of the Rules. The Tribunal's full written determination is included at Annex C.

12. On 22 July 2022, a matter arose during Dr Nadal's cross-examination. The hearing continued in private session to explore the matter. Following an adjournment, the hearing reconvened and the Tribunal determined that it was appropriate, under Rule 41 of the Rules, to proceed in private whenever further evidence or submissions on the matter arose.

13. On 26 July 2022, the Tribunal, for the reasons detailed in its determination at Annex D, determined that the hearing should be adjourned, and further case management directions were made. The Tribunal's decision on adjournment and its directions for parties is included at Annex D.

14. When the hearing reconvened on 21 February 2023, Mr Geering, Counsel, appeared on behalf of Dr Nadal, in place of Mr Edis QC. The Tribunal granted the application made on behalf of Dr Nadal, to admit further evidence relating to the matter that arose on 22 July 2022. The GMC did not oppose this application. The Tribunal determined that it was fair and relevant to admit the further evidence.

15. The Tribunal granted the application made on behalf of the GMC to amend paragraph 8 of the Allegation under Rule 17(6) of the Rules. Dr Nadal did not oppose the application. The Tribunal was satisfied that the amendment, which corrected a possible error as to the date of Dr Nadal's conversation with Ms E, could be made without injustice.

16. XXX.

The Allegation and the Doctor's Response

17. The Allegation made against Dr Nadal is as follows:

~~Patient A~~

~~1. On 16 March 2016 your decision not to repatriate Patient A was inadequate in that you failed to:~~

~~a. ascertain the level of care being provided at the host hospital ('Myung Sung Medical Centre') in respect of:~~

~~i. medical and nursing staff;~~
~~ii. clinical facilities;~~
~~iii. cleanliness;~~
~~iv. treatment options available;~~

~~b. ascertain whether a better level of care could be provided on the African sub-continent resulting in reduced transfer times;~~

~~c. adequately assess the risk versus benefit of aeromedical transfer taking into account the factors as set out in paragraphs 1.a and/or 1.b.~~

Deleted in its entirety following successful 17(2)(g) application

Patient B

2. Between 30 June and 9 July 2017, your ongoing decision-making relating to the repatriation of Patient ~~XX~~ B was inadequate in that you failed to:
Amended under Rule 17(6)

a. obtain any medical information regarding Patient B's clinical condition until 7 July 2017;
To be determined

b. have the Turkish medical report received on 4 July 2017 translated in the UK;
To be determined

c. monitor Patient B's treatment and progress at the host hospital ('Yucelen Hospital Mugla');
To be determined

d. discuss Patient B's case with:

i. his UK Consultant Haematologist ('Dr C') to utilise the specialist advice being offered to you; To be determined

ii. an air ambulance company for advice about the risks of repatriation; To be determined

e. pursue early aeromedical repatriation having regard to:

i. Patient B having a complex, rare and life-threatening condition that required specialist care; To be determined

ii. the necessary clinical expertise on Patient B's condition not being available at the host hospital; To be determined

~~iii. the host hospital and / or treating clinician being reluctant to facilitate Patient B's transfer to the state hospital ('Mugla State University Hospital').~~
Deleted following successful 17(2)(g) application

3. From 5 July 2017 onwards, your care of Patient B was inadequate in that you failed to:

a. ensure the telephone calls from Patient B's family were returned in a timely manner; To be determined

b. return Dr C's telephone calls. To be determined

4. On 10 July 2017, your communication with Patient B's family was inappropriate in that:

a. your attitude was uncaring and unprofessional; To be determined

b. you gave advice about blood transfusion which served no purpose; To be determined

c. you shared an unprofessional opinion about:

i. Dr C's letter dated 5 July 2017 being very unhelpful to you; To be determined

ii. the ability of Worthing Hospital to manage Patient B's condition effectively; To be determined

~~d. you did not end your conversation with a definitive plan:~~

~~i. about the transfer;~~

~~ii. when you would contact Patient B's family again and /or when further contact would be made.~~
Deleted following successful 17(2)(g) application

Patient D

5. Between 28 February and 4 March 2018, your care of Patient D was inadequate in that you failed to make any direct contact with the treating clinician to monitor Patient D's clinical condition and progress.
To be determined

6. From 21 February 2018 onwards, your decision not to repatriate Patient D was inadequate in that you failed to:

a. have sufficient regard to the fact Patient D:

i. had suffered a major cardiac event on the background of chronic cardiac disease; To be determined
ii. had a life-threatening condition; To be determined
iii. did not initially have a rapidly deteriorating condition; To be determined
iv. would likely need to wait at least a month for cardiac catheterisation locally; To be determined
~~v. would require helicopter transfer to another island for cardiac catheterisation at the Dr Negrin Hospital~~;
Deleted following successful 17(2)(g) application

b. have sufficient regard to the treating clinicians view that Patient D:

i. required urgent catheterisation with or without treatment; To be determined
ii. would die without cardiac catheterisation, as related to you by the Consulate Representative (Ms E); To be determined

~~c. have sufficient regard to the limited cardiology facilities at the host hospital ('General Hospital Arricefe')~~
Deleted following successful 17(2)(g) application

d. seek advice from:

i. the treating clinicians; To be determined
ii. a UK cardiologist; To be determined
iii. an air ambulance company; To be determined

e. adequately assess the risk versus benefit of aeromedical transfer by taking into account the factors as set out in paragraphs 6.a to 6.d.
To be determined
Deleted following successful 17(2)(g) application in respect of paragraph 6.a.v and 6.c

7. On 28 February and 1 March 2018, your communication with Patient D's family was inappropriate in that you:

a. justified why air transfer to the UK was not possible by giving irrelevant, unsubstantiated and / or exaggerated risks regarding the air environment being:

i. low in pressure; To be determined
ii. low in oxygen; To be determined
iii. extremely dry; To be determined
iv. very high in ozone concentrations; To be determined
v. subject to acceleration forces; To be determined

b. claimed if you approved air transfer and Patient D died enroute, you might face manslaughter charges; To be determined

c. provided your personal political views on healthcare within the EU and the UK which had no relevance to Patient D's care; To be determined

d. provided observations about Spanish private health care facilities that may not have been appropriate; To be determined

e. made disparaging remarks about the input of Consular staff and knowledge of aviation medicine of specific nationalities; To be determined

f. stated delays for cardiac intervention in the UK were the worst in Europe; To be determined

g. mentioned other cases of repatriation in which the patient died; To be determined

h. stated that the UK government delayed issuing Provisional Replacement Certificate to reduce costs; To be determined

~~i. failed to provide any degree of reassurance to the family concerns or that you were acting in Patient D's best interests.~~
Deleted following successful 17(2)(g) application

8. On 1 or 2 March 2018, your communication with Ms E was inappropriate in that your attitude was condescending and unhelpful.
Amended under Rule 17(6)
To be determined

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

Witness Evidence

18. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Ms A, wife of Patient A;
- Mr AA, son of Patient A;

- Dr J, Neurosurgeon at Addis Ababa University;
- Dr K, General Practitioner Partner at Groombridge and Hartfield Medical Group;
- Ms BB, wife of Patient B;
- Ms B, mother of Patient B;
- Dr C, Consultant Haematologist at Worthing Hospital;
- Ms D, Patient D's daughter;
- Ms DD, Patient D's daughter.

19. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Ms L, Head of Consular Assistance at the Foreign and Commonwealth Office (FCO);
- Mr M, Paralegal at the GMC;
- Dr H, GP Partner at Roseneath Medical Practice;

20. Dr Nadal provided his own witness statements dated 16 July 2021, 21 July 2021, 24 August 2021, 1 December 2022. Dr Nadal gave oral evidence at the hearing.

Expert Witness Evidence

21. The Tribunal also received evidence from three expert witnesses. Dr P, a Consultant Anaesthetist, was called by the GMC. She provided an expert report dated 1 March 2018 with a supplementary report dated 29 May 2019. These reports were aimed at assisting the Tribunal in understanding Dr Nadal's standard of care in relation to the case of Patient A. Dr P gave oral evidence at this hearing. Having found that there was no case to answer in respect of Patient A, the Tribunal did not have any further regard to Dr P's evidence in its consideration of the outstanding paragraphs of the Allegation.

22. Dr Q, a Consultant Anaesthetist and Aeromedical Repatriation Specialist, was called by the GMC. He provided an expert report relating to Patient B dated 28 November 2019 and another report relating to Patient D dated 9 December 2019. In addition, Dr Q provided a further report, dated 16 September 2021, relating to both Patients B and D. These reports were aimed at assisting the Tribunal on the conduct of Dr Nadal in his role as Medical

Director of EAF whilst acting on behalf of TIF and Dr Nadal's standard of care in relation to Patient B and Patient D. Dr Q gave oral evidence at this hearing.

23. Professor R, Medical Director of the Air Ambulance Company 'Jetcall', provided an expert report dated 19 July 2021 aimed at assisting the Tribunal as to the safety of transporting Patient B, from Turkey, and Patient D, from Spain, by air ambulance back to the UK. Professor R did not attend the hearing to give oral evidence. The evidence of Professor R was not agreed by the GMC and his report was admitted as hearsay evidence.

Documentary Evidence

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

- Transcript of calls between Dr Nadal and Ms BB, dated 10 July 2017;
- Transcript of calls between Dr Nadal and Ms D, dated 28 February 2018 and 1 March 2018;
- Medical records for Patient B and Patient D;
- Travel Insurance Policies for Patient B and Patient D;
- EAF Event Logs for Patient B and Patient D recording communications/actions in relation to the cases of Patient B and Patient D, various dates.

The Tribunal's Approach

25. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Nadal does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

26. The Tribunal determined to first set out its global observations and detail the relevant chronologies in relation to Patient B and Patient D. It then considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

The Tribunal's Analysis of the Evidence and Findings

27. The Tribunal reminded itself that the Allegation relates only to Dr Nadal's alleged personal failings in respect of Patient B and Patient D. It is not alleged that he was responsible for the failings of others in EAF or otherwise failed in his supervision of others. In this respect, the Tribunal was mindful that Dr Nadal could not be criticised for the failings of others at EAF or for failing to act in relation to matters of which he was unaware and which he could not reasonably be expected to have been aware. The Allegation is limited to Dr Nadal's personal involvement and responsibility in each case.

Duty

28. The Tribunal acknowledged that in relation to those paragraphs of the Allegation that allege a failure, or inadequate decision-making or care, there must first be an identifiable duty. The Tribunal acknowledged that the relationship between Dr Nadal and respectively, Patient B and Patient D, was not a 'doctor/patient relationship'. Therefore, Dr Nadal's duties to Patient B and Patient D were not those which such a relationship would necessarily imply. The Tribunal considered that Dr Nadal's duty was to exercise the care that might reasonably be expected of a registered medical practitioner of Dr Nadal's qualification and experience performing the role of an 'Assistance Medic'.

29. In determining Dr Nadal's role as an 'Assistance Medic', the Tribunal had regard to a letter from Viridian Law, dated 27 October 2018, Dr Nadal's previous solicitors, which stated as follows:

> *'The Doctors' role*
> *Dr. Nadal acts as the Medical Director of the Medical Team advising insurers upon claims arising from travel insurance policies handled by Travel Insurance Facilities plc ("TIF")…*
>
> *The Medical Team at TIF comprises a team of 4 doctors (working full or part time), and 2 nurses, and they work along side operational staff. As the most senior and experienced member of the Medical Team difficult medical cases may be escalated to Dr. Nadal…*
>
> *The role of the Medical Team.*
> *When an enquiry is passed to the Medical Team by the operations team the Medical Team's role is not to manage cases from the medical point of view. The operations team will have received a call from the patient, a relative or the hospital, and will have*

obtained information as to the patient's condition. They will refer the case on to the Medical Team if they think it needs more specialist handling. The Medical Team is informed of the treatment being proposed for the purposes of providing the following services to the Insurer: (i) In consultation with non medical colleagues, to apply the travel insurance policy appropriately, and having done so the insurer will confirm cover if the case falls within the terms of the policy. (ii) To advise the insurer so as to enable it to transfer the patient at the right time and in the right way. It is an important principle of authorising any action not to cause harm to the patient, and an ill advised transfer when contra-indicated can cause harm to the patient…

The doctors and other staff in the Medical Team do not provide medical treatment. They do not direct care… The local hospitals and the treating doctors are responsible for the management of the patient and provide the medical treatment. Even when transfers are arranged from one hospital to another hospital by way of air ambulance, continuous treatment is maintained and passed from the hospital to the transferring Doctor and on to the receiving hospital facility. The decisions as to what treatment to request and accept remain with the patient and their family…

The Medical Team advises the insurance company when to arrange a patient transfer. In the case of a prospective transfer it will monitor a patient's treatment and progress with a view to deciding whether and when the insurance company should consider authorising a transfer. It is always open to the patient, or their next of kin, to take their own course. They decide with the hospital and surrounding medical services, or other doctors that they choose to consult, what treatment to accept…'

30. The Tribunal recognised that there were clear limits to Dr Nadal's role as an 'Assistance Medic' and what the requirements of that role were. The Tribunal accepted that it was not Dr Nadal's responsibility to make treatment decisions or advise on the treatment a patient should be receiving. He did not, as he accepted, have the relevant clinical expertise for that, nor would it have been appropriate for him to do so. However, that is not to say that the advice Dr Nadal gave the insurer in respect of repatriation (i.e. *'the right time and the right way'* to transfer a patient), would not impact upon the treatment the patient *might* ultimately receive. Plainly, Dr Nadal's advice could affect a patient's treatment in that, if, following his advice to the insurer, a decision was taken not to repatriate, a patient would remain in the host country for treatment. In these circumstances, the Tribunal considered that Dr Nadal owed a duty of care to both the insurer and the insured in relation to the advice he was giving with regard to repatriation.

31. The Tribunal acknowledged that to be an 'Assistance Medic', a person does not necessarily have to be on the medical register or have a licence to practise. However, the Tribunal was satisfied that if an 'Assistance Medic' is registered with the GMC and holds a licence to practise then they are required to comply with Good Medical Practice (GMP) insofar as they relate to the performance of a registered medical practitioner in the role of an 'Assistance Medic'. The Tribunal was satisfied that Dr Nadal, as a registered medical practitioner with a licence to practise, was, at the relevant time, bound by GMP whilst performing his role as an 'Assistance Medic'.

GMP

32. Dr Nadal accepted in evidence that he was, at the relevant times, bound by the principles of GMP. The Tribunal considered that the following paragraphs of GMP were particularly relevant to the outstanding paragraphs of the Allegation to be determined and formed part of Dr Nadal's duties as an 'Assistance Medic':

> ***4*** *You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.*
>
> ***7*** *You must be competent in all aspects of your work, including management, research and teaching.*
>
> ***14*** *You must recognise and work within the limits of your competence.*
>
> ***31*** *You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> ***32*** *You must give patients[20] the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
>
> (Footnote 20) *Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.*

33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34 When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

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

36 You must treat colleagues fairly and with respect.

54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.

33. Having identified the general nature and extent of Dr Nadal's duty as a registered medical practitioner performing the role of an 'Assistance Medic' bound by the provisions of GMP, the Tribunal went on to consider what this meant in practice.

34. In the light of Dr Q's evidence, the Tribunal considered that Dr Nadal's role required him to perform a risk assessment balancing the relative risks/benefits of an insured patient being repatriated to the UK for treatment as against remaining in the host country for treatment and care until such time as it was appropriate for them to be repatriated. Dr Nadal seemingly accepted Dr Q's evidence in this respect. The performance of this necessarily required Dr Nadal to obtain as much information as the circumstances required and reasonably allowed for the assessment to be made and in such time as the circumstances required.

35. Further, the Tribunal accepted that Dr Nadal had a duty to keep his assessments and decisions/advice as to whether a patient should be repatriated under review having regard to changing circumstances of which he was, or should have been, aware.

36. Dr Nadal had a duty to work within, and recognise, the limits of his own competence. Whilst he could rely on his own knowledge and experience, he had a duty to seek specialist advice in relation to matters that were outwith his knowledge and experience. He needed to be aware of, and have regard to, those matters in respect of which he did not have any, or any sufficient, information. It was a theme in Dr Nadal's evidence, which the Tribunal

accepted, that he recognised that in the performance of his role, he was required to identify 'known unknowns', that is to say, he should recognise when there were matters he did not know the answers to and to which he needed to either find more information about, or make allowance for, in order to make an informed decision.

37. The Tribunal considered that, in the performance of his role as an 'Assistance Medic', Dr Nadal was entitled to expect, in the absence of evidence to the contrary, that treating doctors are competent. However, if he was made aware of matters that caused him to suspect, or believe, that a patient was not receiving the treatment they required, or they were not receiving optimum care, Dr Nadal had a duty to act on that suspicion or belief. For example, Dr Nadal could use his own knowledge and experience of other countries and their healthcare systems to support his decision-making. He was entitled to assume that if a treating doctor was in a country with a well developed and regulated healthcare system, he could use that information to conclude that the patient was receiving adequate treatment. But, if he received information which suggested otherwise, he was required to act on that, be that by seeking further information or taking other appropriate action.

38. In relation to the paragraphs of the Allegation concerning the alleged inappropriateness of his communications with members of Patient B's and Patient D's families, the Tribunal had the relevant transcripts of Dr Nadal's conversations and it had heard the recordings of the calls with Ms BB and Ms D and it had heard Dr Nadal give oral evidence in relation to the same. The Tribunal considered that, in accordance with GMP, Dr Nadal was under a duty to communicate appropriately and professionally with patients, their families and those concerned in their treatment.

39. Despite the submissions made on behalf of Dr Nadal, the Tribunal did not consider that the duty which Dr Nadal owed to the insurer created any impediment to the basic requirements of GMP in relation to his communications with a patient and/or their family.

40. The Tribunal acknowledged that an assessment of the appropriateness and/or professionalism of Dr Nadal's communications would necessarily be fact-specific and require consideration of the context in which Dr Nadal was speaking.

41. The Tribunal was satisfied that there was no significant conflict between Dr Nadal's role as an 'Assistance Medic' and his duties as set out in GMP. In particular, it considered that in his direct dealings with patients, their families and others, there was no conflict between

the duties required by GMP and his duty to his principal, the insurer, as had been submitted by Mr Edis QC at an early stage of the hearing.

42. The Tribunal considered that it was possible to be appropriate, professional, polite, sensitive, and mindful of relevance, even when delivering bad news or information that a patient and/or their family may not want to hear.

Assessment of Expert Evidence

43. Mr Geering referenced the expert opinion evidence given by Dr P in relation to Patient A and submitted that Dr Nadal should not be judged against the standard of a 'Consultant-level doctor' as she had opined. The Tribunal accepted this submission. The observations that the Tribunal had made in respect of Dr P's evidence in its Rule 17(2)(g) determination, at Annex C, were solely in relation to Patient A and the Tribunal had no regard to Dr P's opinion evidence in relation to its determination in respect of Patient B and Patient D.

44. In respect of Patient B and Patient D, the standard against which Dr Q measured Dr Nadal was the standards of a registered medical practitioner. The Tribunal was satisfied that the standards of a registered medical practitioner was the appropriate standard against which the conduct of Dr Nadal should be judged.

45. In respect of Dr Q, the Tribunal acknowledged that he was a Consultant in Anaesthesia and Intensive Care, and that he had significant experience and expertise in aeromedical repatriation far beyond the level of knowledge and experience that might reasonably be expected of Dr Nadal. Conversely, Dr Q was not an 'Assistance Medic', and he did not have experience in that field, nor did he have a detailed knowledge or experience of private/public healthcare provision abroad in either Spain, the Canary Islands or Turkey. Dr Q had, however, extensive experience of repatriation decision-making and the risk assessment that such decision-making required, comparable to that which Dr Nadal was required to undertake, and was undertaking, albeit not in the context of advising an insurer as to whether an aeromedical transfer was medically necessary for an insured.

46. The Tribunal was mindful of the fact that the Allegation was not about clinical competence. The Allegation focused on decision-making and risk assessment and interpersonal matters covered by GMP, primarily regarding aeromedical repatriation. To this extent the Tribunal was satisfied that Dr Q's expert evidence was admissible and relevant.

47. Accordingly, the Tribunal accepted that Dr Q's overarching opinion that Dr Nadal had a responsibility to perform a risk/benefit analysis in the cases of Patient B and Patient D as it related to possible repatriation was relevant. However, the Tribunal bore in mind that Dr Nadal could not have been expected to have the specialist knowledge or exercise the degree of detailed risk/benefit analysis that Dr Q would have done in performing his role as an aeromedical repatriation expert.

48. Furthermore, the Tribunal was mindful that Dr Q's role would usually only be required once a repatriation had been decided on. The Tribunal determined that from the point at which it was decided that aeromedical repatriation might be required, Dr Q's expert opinion evidence was valid. The Tribunal was satisfied that Dr Q gave his evidence based solely on his expertise. His evidence had been tested under cross-examination and Tribunal questions, and Dr Q had made concessions where appropriate.

49. The Tribunal accepted that throughout its deliberations, it must be cautious not to judge Dr Nadal against the standard of Dr Q's specialism and expertise.

50. In respect of Dr Q's opinion on the appropriateness of Dr Nadal's communications with members of Patient B's and Patient D's families, the Tribunal was of the view that Dr Q had sufficient expertise to express an opinion. However, in the event, the Tribunal considered that save where the communications related specifically to opinions on medical matters, the Tribunal was able to form its own view on the appropriateness or otherwise of Dr Nadal's communications.

51. In respect of Professor R, for the same reasons, the Tribunal considered that it was entitled to have regard to his opinion evidence. It noted that he was closer in specialism to Dr Q than Dr Nadal. However, it bore in mind that Professor R's observations arose solely from the evidence of Dr Nadal, whereas Dr Q had been provided with Dr Nadal's account of events as well as that of the GMC's witnesses. The Tribunal was mindful that Professor R had a professional relationship with Dr Nadal and that he had declared an interest insofar as he had been employed by EAF to carry out aeromedical repatriations. It was also relevant to the attribution of weight to give Professor R's evidence that he had not given oral evidence and it had not tested in cross examination.

52. Having concluded its global observations about the case, the Tribunal went on to consider the specific paragraphs of the Allegation in relation to the case of Patient B.

Patient B

53. The Tribunal had already determined that part of Dr Nadal's role was to advise the insurer as to whether an insured patient needed to be repatriated to the UK. In so doing, he was required to comply with the relevant provisions of GMP and, in particular, to work within his competence.

54. Paragraph 2 of the Allegation referred to Dr Nadal's 'ongoing decision-making'. The Tribunal considered that Dr Nadal was under a duty to keep under review his advice to the insurer regarding any decision as to repatriation and, to this extent, he had an ongoing duty to review his decision-making. If, having initially decided that the circumstances did not require a patient to be repatriated but the circumstances later changed, such that repatriation might become necessary, then Dr Nadal was under a duty to reconsider his initial decision.

55. As the Tribunal had already observed, the Allegation in this case was not that EAF failed in their duty to Patient B or that Dr Nadal was responsible for the failings of others at EAF. The Allegation specifically focused on Dr Nadal's personal failure. This meant that he could not be held responsible for organisational failures and that his duty with regard to Patient B would not have started earlier than the point at which he was first consulted about and/or took responsibility for the case.

Patient B – Chronology

56. The Tribunal had regard to the chronology it set out in Annex C. Since that chronology had been produced, the Tribunal were furnished with a more complete copy of the EAF event log. Accordingly, the Tribunal considered the chronology of Patient B's case afresh, taking into account the more detailed event log as well as the other contemporaneous documentary evidence. The following are extracts from the more complete copy of the event log, which were taken into account by the Tribunal, which had added a commentary where relevant:

30 June 2017

Event Log – 15:36 – *Pax* [Policyholder i.e. Patient B] *was rush in hospital yesterday night due to his pmh* [past medical history] *Evans syndrome. he had soime blood transfusion and he si currently at Mugla yucelen hospital*

Event Log – 16:51 – *Call to* [Ms BB]*, pax was transferred to Mugla Yucelen hospital, no advice has been given about transferring to public it seems. Yucelen of course have shown no interest in the insurance, have made her sign lots of forms and are giving under par treatment as he is now captive. I suggested that she tell he clinic she canot pay for this and wished him t be transferred to an appropriate public facilis he is haemolysing and needs constant transfusions. She says the treatment he is being given is mcuh less aggressive than what he would receive in the UK. I advised her to ask for a MR* [Medical Report] *and request transfer to public*

Event Log – 18:26 – *Call from Pax mum in UK* [Ms B]*. Hospital are arranging transfer but have asked that pax sign a form saying he does not want anymore treatment. advised that if pax needs treatment he should have it and whole transfer is taking place they are not liable for bills.*

1 July 2017

Event Log – 13:00 – *Call from* [Ms BB]*, pax is not well enough to be transferred to Public. is in an ADU bed. they have been paying the hospital, advised not to pay any more and they should ask the hospital to contact us directly.*

Event Log – 22:33 – *Rang the hospital and attempted to get a fax or email in order to send MR request but the hospital not very understanding, email sent to* [Ms BB] *to see if she can assist in getting MR*

2 July 2017

Event Log – 20:36 – *I called the hospital to try and speak to TD* [Treating Doctor] *but they transferred me to the pax room. I spoke to pax mother who advised that she has been trying to obtain the MR but the TD is not very forthcoming, she managed to get UK GP to email over pax notes to advise the TD what treatment pax needs but he refused to read them or make contact with the UK GP to discuss… pax mother very worried as she fears pax is not getting the treatment he needs.*

3 July 2017

12:40 - Email from the host hospital to EAF:

> *'Subject:* [Patient B]*… GETTING TREATMENT AT MUGLA YUCELEN HOSPITAL AND NEED AIR AMBULANCE TRANSPORTATION HIS SITUATION SERIOUS*
>
> *Attachments: [Patient B] TURKISH REPORTS.pdf*
>
> *Importance: High*
>
> *Dear Sir, Madam;*
> *Attached files you can see* [Patient B]*'s situation. He's serious hemolitic anemic patient. His body does not answer his treatment. Please arrange for him air ambulance transportation.*
> *Sincerely,'*

14:48 – Email from Ms BB to EAF:

> *'…Update regarding my husband. The hospital have said today they will not deal with yourselves as they had a previous issue with another patient with you. They have suggested air ambulance back to UK when his hb* [haemoglobin] *reaches 8 but only if they organise it. We need you to be aware of this and we are also informing the British Embassy.*
>
> *Would you be able to liaise with the embassy ?* [Dr C] *his uk consultant has forwarded details of his condition to the embassy'*

4 July 2017

Event Log – 06:51 – *Document Uploaded:* [Patient B] *TURKISH REPORTS*

Event Log – 06:52 – *Document Uploaded: email from hospital* [Patient B]

Event Log – 15:29 – Email from EAF to Ms BB in response to the email above:

'Thank you for your email . [Patient B's] *case is currently being reviewed by our medical team . As soon as we have updates from them we will be in touch regarding repatriation'*

5 July 2017

Event Log – 09:11 – *Completed Task – R URGENT pls review MR Dr states pax should be medivac to UK*
[Entry recorded as task completed by Dr G, a member of the medical team]

Event Log – 09:15 – *MR in turkish , please translate and revert to MT , I will discuss case with* [M]*JN* [Dr Nadal] *also ,*

13:46 – Email from Ms BB to EAF:

'Do you have an update we are being asked to pay more money and we need to know if you are taking care of his bills. Dealing with the financial side of things is making a very stressful situation even worse. The hospital want money today. I was previously told not to pay anymore but it seems that yourselves have not taken over payment.

We have been told by the hospital they will arrange transport to an air ambulance if this was arranged but want us to his bills to be able to arrange this.

We need to get home he as he is not getting much better here. Please help us.

I appreciate a response asap…'

Letter dated 5 July 2017, emailed at time unknown but uploaded to Event Log, 6 July 2017 at 20:34 from Dr C, Patient B's UK Consultant Haematologist:

'Diagnosis: Refractory AIHA [Autoimmune Haemolytic Anaemia]

This gentleman had life threatening haematological condition that requires specialist care urgently. He is being managed in a hospital in Turkey at present. His condition is said to be somewhat stable but he is seriously unwell. He is

understandably anxious as he is in a foreign country unable to communicate effectively with nurses and doctors' due to language barrier. The hospital he is currently admitted is not a centre specialised in haematological diseases although there is some input from a haematologist in a distant hospital.

I am concerned that any further delay in repatriating this gentleman home might seriously affect his chances of survival.

I would be grateful if you could help this gentleman get back to Worthing Hospital urgently.'

6 July 2017

Event Log – 06:51 – Complete Task – *Please send MR for translation its in Turkish*
[The event log indicates report sent to remote translation company 'Integro']

14:04 – Email from Ms BB to EAF

'I am still waiting for a response regarding my husbands treatment and payment . I have sent 2 emails and made 2 phone calls since this email was sent to me and had no response or call backs.

Please let me know what is happening with regards to paying the hospital they are still demands payment from us.

His consultant in England has also emailed you to inform you about my husbands urgent situation.

Please contact me'

Event Log – 15:13 – *Document Uploaded:… further email from* [Ms BB] *re no callback.pdf*

Event Log – 15:29 – *Pax wife called for update. Explained we are waiting for integro and will be in touch once MT have reviewed*

16:32 – Email from Ms BB to EAF:

'Following my conversation with [Mr U] *I would like to document our conversation via email. He confirmed that the hospital need to contact the insurance company regarding payment for* [Patient B's] *emergency admission. He also clarified that we are waiting for the medical report to be translated to English and review by the medical team. Then somebody will reply to me.'*

Event Log – 20:34 – *Document Uploaded: Haem* [Dr C's secretary] *05-07-2017 gp.pdf* –
[Letter from Dr C, Patient B's UK Consultant Haematologist dated 5 July 2017, sent by his secretary]

7 July 2017

11:18 – Email from Ms BB to EAF:

'I would just like to update yourselves on my husbands condition.

He has been experiencing problems with his heart the doctor believes this is due to the high dose steroids he gas been on as treatment for his low haemoglobin. His blood sugar has been tested and is high therefore he is being given insulin intravenously.

This updated medical report is being sent to yourself in English by the translator here.'

15:01 – Email from Ms B to EAF:

'Dear sirs,…[Ms BB] *has been in contact with you regarding* [Patient B's] *current condition in mugla yucelen hospital, he is seriously ill and we are fearing the outcome, she has phoned yet again today, only to be told for the 3Rd time that someone will phone her back I am currently looking after* [Patient B] *in the hospital, as the nurses have no input or English, the hospital say they do not deal with* [you] *because of past issues, this is not my son's fault, you should have, today, received an updated medical report in English and an email from* [Patient B's] *consultant in England outlining the seriousness of the situation here, I feel I am adjust sitting here watching my son die, we*

Desperately need you help to repatriate him at the your earliest convenience as we do not have thefunding needed to do this ourselves.'

[The Tribunal could not identify a record from which it could infer that this specific email, from Ms B, was uploaded to EAF's database. Communications and documents were received and uploaded but it was not clear whether this email had been uploaded or would otherwise have been seen by Dr Nadal at the relevant time.]

Event Log – 15:26 – *Document Uploaded:* [Patient B] *ENGLISH REPORT 07.07.2017*

Event Log – 15:48 – *Call from pax wife concerned as pax is worsening. She said hospital have sent MR, I found it in inbox and tasked to MT* [Medical Team]. *Spoke to* [Dr G] *about case, he said passed to MJN* [Dr Nadal], *rant* [rang] *MJN, no answer*

Event Log – 16:29 – *Update MR ; stated pax had initiated treatment with Mabthera – also suggest pax is not suitable to transfer to public ?? stable , Hb 7,9 , on AF* [Atrial Fibrillation] *, with transfusion , no sigs of acute bleeding Called received from operation : advise to contact MJN – as we discussed the case on 5 th July – he agree he need cloth* [close] *monitor .*
[Entry as recorded as having been made by Dr G]

[The Tribunal considered that it was unclear from the events log and evidence whether Dr G had initially only sought advice from Dr Nadal or had asked him to take over the case. It was also unclear precisely when the case was formally *'passed to MJN'*, but, as was accepted by Dr Nadal, the case had been passed to him by no later than 7 July 2017.]

Event Log – 17:04 – *Spoke to MJN and advised him new MR in and pax was deteriorating*

[No activity by the medical team was recorded as having taken place on 8 July 2017.]

<u>9 July 2017</u>

Event Log – 17:33 - *…*URGENT* Calling in regards to her son,* [Patient B]. [Ms B] *needs an update on his repatriation. She has emailed several times and called numerous times also.* [Ms B] *states you should have received a letter from their consultants in the UK regarding repatriation. She has provided a Turkish medical*

report, and English medical report and received no response. [Ms B] *needs a callback URGENTLY as she is led to believe that he will die if not sorted out.* [Ms B] *stated she has a consultant happy to speak with your consultant, his number will be on the headed letter already provided. The Dr is* [Dr C].

Event Log – 17:34 – *Call to MJN, he is aware of case and will try to call pax wife in turkey later to discuss*

Event Log – 21:53 – *MJN has read the file. He notes that that pax is still in a private hospital; his condition requires a public university hospital. MJN has seen no evidence of pax having declared his PMH nor of his case having been escalated to establish cover. This must be done as a matter of urgency on Monday morning without fail*
[This was the first entry from Dr Nadal shown in the Event Log]

10 July 2017

Event Log – 10:39 – *Call from* [Ms BB] *for updates adv hospital is not given any blood to husband. I called MJN to adv that PMH was declared when PAx purchased policy. I transferred* [Ms BB] *to speak to MJN*

Event Log – 11:27 – *MJN has spoken to underwriting and health-check screening was done by* [another entity].
[Entry by Dr Nadal]

Event Log – 11:29 – *MJN has spoken to* [Ms BB] *who is a midwife. MJN explained why he thinks the treating doctors do not understand this disease and how to treat it properly. MJN indicates that we shall be planning an AA transfer as long as an AA company is prepared to carry pax with a Hb of 6g/dL.*
[Entry by Dr Nadal]

Event Log – 14:35 – *call from* [Ms BB] *adv that* [Dr C]*… will call to MJN and hse is given permission to speak to him*

Event Log – 16:02 –…[Ms BB] *requesting immediate call back, has been waiting for call for medical director since yesterday afternoon.*

Event Log – 16:06 – *called pax* [likely a family member] *and mentioned that our repat/MJN will deal with the AA and will contact the family with an update once AA is arrange*

11 July 2017

Event Log – 04:44 – *Email from* [Ms BB] *to advise that pax is having 2x pints of blood this evening 10/7/17*

Event Log – 10:09 – …[Ms BB] *is calling to chase an update on her husband who is waiting on a air ambulance in Turkey…*

Event Log – 10:10 – *PAx was transfer to a public hospital Mugla University Hospital*

Event Log – 10:14 – *I adv we are still awaiting on MJN/repat to get AA done*

Event Log – 17:40 – *Spoke with MJN – he is trying to get clearance and it is in hand*

Event Log – 19:34 – *Called* [Ms B] *for update… Mentioned that MJN is dealing with it atm. mother has passed the contact number of the interpreter…*

Event Log – 20:35 – [Entry indicated MJN sent x2 AA [Air Ambulance] and further quote awaited]

12 July 2017

Event Log – 08:43 – *call from* [Ms B] *adv PAx has died in Turkey…*

Dr Nadal's case in respect of Patient B

57. It was Dr Nadal's evidence that he was first aware of Patient B's case on 5/6 July 2017, when Dr G consulted him. The event log suggested it was 5 July 2017. Dr Nadal stated that he did not have a clear recollection of his conversation with Dr G. He said he recalled that both he and Dr G were unsure about what to do. Dr Nadal said that Dr G was relatively inexperienced in his role as an 'Assistance Medic' having been in post for less than two years. It was Dr Nadal's evidence that it takes two years to become fully trained for this role.

58. Dr Nadal said in his oral evidence that once he was made aware of the case by Dr G, he considered the content of the untranslated Turkish medical report received on, or around, 4 July 2017. He said that although he did not speak Turkish and he could not translate the report, he was able to interpret Patient B's laboratory results and the nature of the treatment being given. Dr Nadal confirmed that on 5/6 July 2017, he would have scanned through the event log and that he would have read all of the *'key entries'*. He said he usually did this when taking over a case, and in Patient B's case specifically, he said he had also wanted to ensure that EAF staff were doing their jobs properly. Dr Nadal believed he had read Dr C's letter during this period but was unsure when he had done so. There was no entry to confirm Dr Nadal's review in the event log. His first entry in the event log of his having reviewed the case was on 9 July 2017.

59. Dr Nadal said that Dr G had reported that he did not know what should be done and Dr Nadal agreed with Dr G that he did not know either. In his witness statement, Dr Nadal stated that at this time, on 5 July 2017, he was concerned as to whether the host hospital, despite being a well-equipped and advanced private hospital, could manage Patient B's condition until the drugs administered took effect. Dr Nadal said he could not judge their ability to treat Patient B. He stated that there were a number of uncertainties at that stage:

> *'115. I looked at the blood report and lab results. I was not sure what we could do either. I said I would look at the case.* [Patient B] *was obviously very ill and was unstable. I knew the Yucelen private Hospital was a well equipped and advanced hospital. I have known them to carry out interventional cardiology on our clients involving angiography, angioplasty and stent insertion. I had no reason to think that* [Patient B] *was being badly treated there at that time. I was concerned at whether they could manage this condition until the drugs took effect, but I could not judge their ability to treat the patient. There were a number of uncertainties.'*

60. Dr Nadal said that his confidence in the host hospital's clinical competence and ability was supported by his past experience that patients would sometimes be referred from the public university hospital for treatment at Yucelen hospital.

61. However, Dr Nadal was also highly critical of the host hospital. He said that it was his experience, and belief at the time, that the hospital engaged in 'patient trafficking' (the exploitation by private hospitals of tourists requiring healthcare abroad). In his statement, Dr Nadal said:

'127. I was critical of Yucelen Private Hospital's commercial practices, as opposed to their medical practice. They made the hospital stay difficult for our clients. They were expensive by Turkish standards, and they were ruthless in ensuring that they were paid prior to the patient leaving the clinic, without giving the patient a fair opportunity to assess the bill. They would not accept billing instructions from insurers and required full payment in cash before the patient was allowed to leave.

128. We have also in the past found it difficult to obtain medical information from the hospital or speak to their doctors. Their doctors seem not to want to speak to insurance doctors. So I knew it would be difficult to obtain reliable medical information from them.'

62. It was also Dr Nadal's evidence before the Tribunal that although he knew that a number of patients had been treated properly there, he had never been able speak to, or otherwise communicate with, the doctors at the Yucelen hospital despite attempts to do so in relation to other insured patients who had been treated there. He said it was *'impossible'*. He recalled that there was only one occasion when he had managed to speak to a doctor at the Yucelen hospital, and the doctor had simply shouted at him about a failure to pay before the doctor had put the phone down on Dr Nadal. Nevertheless, Dr Nadal was adamant that he believed that the host hospital was clinically competent and that he did not believe that the doctors there would act against their patients' best interests.

63. Dr Nadal's evidence was that following his call with Dr G on 5/6 July 2017, it had been his expectation that the EAF Operations Team would continue to appraise Dr G of any further developments and that Dr G would consult him about any significant changes.

64. Dr Nadal stated in his witness statement that after his call with Dr G, he researched Evans Syndrome, the condition that Patient B had, because he had never heard of it before:

'119. After our call I researched Evans Syndrome. The company case management system – a database available to all those who work in the Medical Team – headlined the condition as Evans Syndrome. In looking it up I discovered that Evans Syndrome was an ultra rare condition characterized by any one, two or three of the following conditions: autoimmune haemolytic anaemia, autoimmune thrombocytopenia and neutropenia. On looking at the blood test results it was evident that the current exacerbation of [Patient B]*'s condition was isolated haemolytic anaemia with a significant mortality rate.'*

65. Dr Nadal's evidence was that he recognised that it was the Autoimmune Haemolytic Anaemia component of Patient B's Evans Syndrome that was described within the first (untranslated) Turkish medical report. In his witness statement, Dr Nadal stated:

> *'124. I don't treat any patients at all, let alone those with ultra-rare haematological condition. I was not researching the condition with a view to treating* [Patient B] *but rather so that I would have a more detailed background knowledge to enable me the better to discharge my duties to advise the Insurer.'*

66. It was Dr Nadal's oral evidence that he looked up Evans Syndrome in two textbooks. The Tribunal noted that during the course of cross-examination, Dr Nadal indicated that he had not researched Evans Syndrome until 9 July 2017 (the date on which the event log records at 21:53 that he had read the file).

67. Dr Nadal was consistent in his acceptance that he was not an expert in haematology, much less was he an expert in this particularly rare syndrome.

68. The Tribunal had regard to Dr Nadal's evidence as to the events of 7 July 2017:

> *'132. On Friday, 7th July 2017 an updated translated medical report came in. It was referred to the Medical Team and reviewed by* [Dr G]. *The report was additionally telling us that* [Patient B] *was suffering from heart failure, atrial fibrillation and shortness of breath. The medical report said that* [Patient B] *was too ill to be transferred the very short distance to the local public hospital. The hospital was much closer by road than the airport would have been had we decided to arrange an air ambulance, so it seemed that the treating medical team was in agreement that* [Patient B] *was too ill to be flown back to the United Kingdom, or even to be driven to the airport.*
>
> *133.* [Dr G] *did not think that the position had changed materially, and* [Patient B] *continued to be treated at the private hospital…*
>
> *142. I think I was involved in the case on the 7th July and I think I discussed it with* [Dr G] *again, but I can't remember the details. We thought that there was very little we could do. However, we thought that it would be better if* [Patient B] *were to be treated in the Mugla State University Hospital.*

143. Through this time, I was very aware of the case and worried about it. I read about Evans Syndrome and tried to think of a better option for [Patient B]. *I also talked to colleagues. No good alternatives seemed to come forward. I became more dismayed. I thought about the air ambulance environment, and the difficulty of carrying blood in a small aircraft. There was always the danger of circulatory collapse. Many complications were possible. In particular, I was concerned about the danger of disseminated intravascular coagulation, and continuing haemolysis during the flight and transfer. I could not imagine an air ambulance crew being comfortable to transfuse blood just prior to flight given the number of blood transfusions that* [Patient B] *had already received and their limited success in improving his condition. I did not think that the potential complications could be treated or controlled during the transfer or in a small aircraft in flight. I thought it was too much of a risk for* [Patient B].

144. I reviewed the translated medical report and the file on Sunday, 9th July. I remained of the opinion that it was not in [Patient B]'s *best interests to be transferred back to England in an air ambulance. I hoped that he would respond to treatment. I certainly expected the treating doctor to seek additional medical counsel, if he needed assistance. I was aware that the consultant was seeking advice from a haematologist at Izmir Ege University Hospital.'*

69. In his oral evidence, Dr Nadal said he considered the translated medical report on 7 July. In respect of the entry from 16:29 on 7 July in the event log, Dr Nadal accepted that Dr G intended to write 'close monitor' rather than 'cloth monitor'. He said that was Dr G's phrase, not his. He said he could not recall any specific discussion of the type of monitoring Patient B's case required. When asked what close monitoring would mean, Dr Nadal said that close monitoring would mean keeping an eye on the case. However, he said there was very little he could do. He said that frequency of monitoring depends on specific circumstances, in particular, the nature of a patient's condition. He said, if a patient was in intensive care, close monitoring would not be required from the perspective of the Medical Team and the insurer.

<u>When did Dr Nadal become responsible for Patient B's case?</u>

70. The Tribunal first considered when Dr Nadal's duty in respect of Patient B began.

71. The Tribunal considered the evidence and determined that on 5/6 July 2017, once he had spoken to Dr G, Dr Nadal must have known that Patient B's case was one that would require his personal attention as Dr G was, as the Tribunal accepted, relatively inexperienced, and still learning. Patient B was obviously an urgent, potentially life-threatening and complicated case and Dr G had told Dr Nadal that he did not know what to do.

72. The Tribunal considered that Dr G's relative inexperience, coupled with Patient B's plainly urgent, potentially complex, and rare condition, led Dr G to speak to Dr Nadal, as head of the Medical Team, about how best to proceed. The Tribunal considered that in these circumstances, even if Dr Nadal had not formally taken over the case from Dr G, as soon as he was aware of it, he should have informed himself as to the facts, kept himself appraised of developments in the case, conducted a risk assessment and given advice as how to proceed. In particular, to urgently advise as to whether repatriation to the UK was in the best interests of Patient B.

73. Dr Nadal's evidence was that he had looked at the events log following his discussion with Dr G. If this was the case, he should have seen the references that had already been made to the seriousness of Patient B's condition, the urgency of the situation, and the need perceived by others for repatriation by air ambulance. Dr Nadal accepted in oral evidence that he had reviewed the event log and noted the *'key entries'*. In the Tribunal's view, the following entries would properly be characterised as key entries:

> 30 June 2017
>
> 15:36 – Pax was rush in hospital yesterday night due to his pmh Evans syndrome. he had soime blood transfusion and he si currently at Mugla yucelen hospital
>
> 16:51 – Call to [Ms BB], pax was transferred to Mugla Yucelen hospital, no advice has been given about transferring to public it seems. **Yucelen of course have shown no interest in the insurance, have made her sign lots of forms and are giving under par treatment as he is now captive**. I suggested that she tell he clinic she canot pay for this and wished him t be transferred to an appropriate public facilis **he is haemolysing and needs constant transfusions. She says the treatment he is being given is mcuh less aggressive than what he would receive in the UK**. I advised her to ask for a MR and request transfer to public
> [The Tribunal's emphasis]

1 July 2017

13:00 – Call from [Ms BB], pax is not well enough to be transferred to Public. is in an ADU bed. they have been paying the hospital, advised not to pay any more and they should ask the hospital to contact us directly.

2 July 2017

20:36 – I called the hospital to try and speak to TD [Treating Doctor] but they transferred me to the pax room. I spoke to pax mother who advised that **she has been trying to obtain the MR but the TD is not very forthcoming, she managed to get UK GP to email over pax notes to advise the TD what treatment pax needs but he refused to read them or make contact with the UK GP to discuss… pax mother very worried as she fears pax is not getting the treatment he needs**.
[The Tribunal's emphasis]

4 July 2017

06:51 – Document Uploaded: [Patient B] TURKISH REPORTS

[The Tribunal determined that this was the medical report which Dr Nadal had seen, in Turkish, and which he had attempted to interpret.]

06:52 – Document Uploaded: email from hospital [Patient B]

> *'Subject:* [Patient B]*… GETTING TREATMENT AT MUGLA YUCELEN HOSPITAL AND NEED AIR AMBULANCE TRANSPORTATION HIS SITUATION SERIOUS*
>
> *Attachments:* [Patient B] *TURKISH REPORTS.pdf*
>
> *Importance: High*
>
> *Dear Sir, Madam;*
> *Attached files you can see* [Patient B]*'s situation. He's serious hemolitic anemic patient. His body does not answer his treatment. Please arrange for him air ambulance transportation.*
> *Sincerely,'*

5 July 2017

09:11 – Completed Task – R URGENT pls review MR **Dr states pax should be medivac to UK**
[The Tribunal's emphasis]

09:15 – MR in turkish, please translate and revert to MT , I will discuss case with [M]JN also ,

74. Having considered the evidence and set out the above chronology, the Tribunal was satisfied that by 5 or 6 July 2017, Dr Nadal had been made aware of Patient B's case. Dr G had, by that point, the Tribunal inferred, appraised Dr Nadal of the essential facts of Patient B's case. Dr Nadal acknowledged that he had sought to interpret the medical report in Turkish, in particular the laboratory results and treatment being given to Patient B. He also confirmed in evidence that he would have looked at the *'key entries'* in the event log because that was his usual practice when taking over a case.

75. In these circumstances, the Tribunal considered that by this time, Dr Nadal had a responsibility with regard to Patient B, to inform his ongoing decision-making, even though he was not solely responsible for the case at this time, as Dr G was still involved. However, by 7 July, as the event log demonstrates, and as appeared to be conceded by Dr Nadal, he had taken over sole responsibility for the case. This was no later than 15:48 on 7 July (as set out in the event log).

Paragraph 2.a

76. The Tribunal was required to determine whether Dr Nadal's ongoing decision-making in respect of the repatriation of Patient B was inadequate because he failed to obtain any medical information regarding Patient B's clinical condition until 7 July 2017.

77. The Tribunal had regard to the event log, the medical reports, various communications from Patient B's family and the host hospital and Dr Nadal's evidence.

78. The Tribunal considered that Dr Nadal was under a duty, for the reasons given above, to obtain medical information from 5/6 July 2017 onwards. This did not mean that Dr Nadal had to obtain the information personally about Patient B's clinical condition. It would have

been sufficient if it were being obtained by others at EAF and Dr Nadal was appraising himself of it.

79. The Tribunal noted that, according to the event log, EAF first requested a medical report from the host hospital, via Patient B's family, as early as 30 June 2017. The event log demonstrates that a medical report was obtained in Turkish and uploaded to EAF's database on 4 July 2017. The Tribunal accepted that Dr Nadal was appraised of the report's content in respect of the laboratory results and of the treatment being given. He received this information either by being told by Dr G about the content of the medical report, as is set out in his witness statement, or having reviewed the medical report himself, as he suggested he had done in his oral evidence. Dr Nadal's evidence was that on 5 or 6 July 2017, he had either discussed the content of the report with Dr G, or he had reviewed the report himself.

80. The Tribunal was satisfied that either way, Dr Nadal had obtained information about Patient B's clinical condition before 7 July 2017. This was confirmed by the event log, the only contemporaneous record of events from the time.

81. The Tribunal considered that, given that the medical report was in Turkish, and Dr Nadal did not speak Turkish, provision of an untranslated copy of the report was insufficient for him to adequately assess Patient B's clinical condition. Nevertheless, the medical report did provide medical information about Patient B's clinical condition and Dr Nadal had considered that report insofar as he was able to recognise some medical terms and data within it.

82. The Tribunal concluded therefore that it could not be satisfied that Dr Nadal had failed to obtain *any* medical information regarding Patient B's clinical condition. The allegation did not relate to the adequacy or otherwise of the medical information obtained.

83. Accordingly, the Tribunal found paragraph 2.a of the Allegation not proved.

Paragraph 2.b

84. The Tribunal was required to determine whether Dr Nadal's ongoing decision-making in respect of the repatriation of Patient B was inadequate because he failed to have the Turkish medical report received on 4 July 2017 translated.

85. The Tribunal had already concluded that Dr Nadal did not have any responsibility for Patient B's case until 5/6 July 2017 when Dr G approached him to discuss the case.

86. It was evident from the event log that by the time Dr G initiated his conversation with Dr Nadal about Patient B's case, Dr G had already requested a translation of the Turkish medical report. He had done so at 09:15 on 5 July 2017. Whilst it does not appear that a translated copy of this medical report was ever received or, at least, uploaded by EAF staff, steps were clearly taken to get it translated. In any event, on 7 July 2017, an updated medical report in English had been received. This report also appeared to include everything that had been included in the first untranslated Turkish report from 4 July 2017.

87. In such circumstances, the Tribunal considered that by 7 July 2017, it had ceased to be necessary for the first report to be translated as it had been superseded by an updated medical report that had been translated in English. The Tribunal inferred that it was more likely than not that Dr Nadal would have been told by Dr G that a translation of the first medical report had been directed. The Tribunal considered that Dr Nadal could not, in such circumstances, be criticised for having done nothing further to obtain a translation of the first medical report. Moreover, such information ceased to be necessary once a translated updated medical report had been received on 7 July 2017.

88. The Tribunal found paragraph 2.b of the Allegation not proved.

Paragraph 2.c

89. The Tribunal was required to determine whether Dr Nadal's ongoing decision-making in respect of the repatriation of Patient B was inadequate because he failed to monitor Patient B's treatment and progress at the host hospital between 30 June and 9 July 2017.

90. The Tribunal considered what duty, if any, Dr Nadal had to monitor Patient B's treatment and progress. It determined that, there was a duty to monitor treatment and progress. That was not to say that Dr Nadal was under a duty to oversee treatment, challenge it, or to enquire into the specifics. It was not his role to do so, and neither would he have had the necessary knowledge or experience to do so. However, the Tribunal considered that it was necessary for the purposes of Dr Nadal's ongoing decision-making that he should have monitored treatment to the extent that he could be reasonably satisfied that Patient B was receiving appropriate treatment, and more importantly monitoring his response to treatment, insofar as was necessary, to assess whether Patient B should remain at the host

hospital for treatment, or whether he should be repatriated to the UK. This would be part and parcel of the risk assessment that Dr Nadal was under a duty to perform.

91. As previously noted, there were entries in the event log prior to 5/6 July 2017 which referred to the inadequacy of the treatment that Patient B was receiving (see event log entry 16:51, 30 June 2017) and the responsiveness of the treating doctors at the Yucelen hospital to Patient B's needs (see event log entry 2 July 2017, 20:36).

92. Furthermore, the Tribunal had regard to the event log entry from 17:04 on 7 July 2017, after Dr Nadal had taken on full responsibility for Patient B's case. That entry confirmed that Dr Nadal had been made aware of a new medical report and that Patient B was deteriorating.

93. The Tribunal considered that, in light of these facts, Dr Nadal had a duty to seek further information about Patient B's treatment and progress. At that stage, having received information that Patient B was deteriorating, Dr Nadal needed to seek information about Patient B's progress, as clearly a deterioration in his condition suggested that the treatment he was receiving at the host hospital was not working and the indications from Patient B's family that the treatment being received at the host hospital was sub-optimal.

94. Dr Nadal had a duty to inform himself of what treatment Patient B was being given and to assess his progress. He had a duty to do so because he had a responsibility for decisions about repatriation from 5/6 July 2017, and such decisions could only be taken with an understanding of Patient B's treatment and progress. Without such information being readily available, Dr Nadal had a duty to seek further information from other sources. He could have attempted to seek further information from the host hospital, even if he believed such information was unlikely to be forthcoming. Further, in the absence of communication from the host hospital, he should have sought further information from Patient B's family who, the event log shows, were engaged in, and informed of, the treatment Patient B was receiving at that time.

95. The Tribunal reminded itself of the letter from Viridian Law that set out the responsibilities of the EAF Medical Team. In that letter, it was stated that *'In the case of a prospective transfer* [the Medical Team] *will monitor a patient's treatment and progress with a view to deciding whether and when the insurance company should consider authorising a transfer'*. It considered that Dr Nadal had, based on his own account provided to his previous

solicitors, confirmed that he had a duty to monitor the treatment and progress of any policyholder that might require repatriation.

96. The Tribunal found no evidence to suggest that Dr Nadal had engaged in any effective monitoring of Patient B's treatment and progress at the host hospital between 5/6 July 2017 and 9 July 2017 or consideration by Dr Nadal as to the issue of whether Patient B needed to be repatriated to the UK for treatment despite having information at this time that Patient B's condition was deteriorating. Indeed, it was only on 10 July 2017, following a conversation with Ms BB, that Dr Nadal appears to have given any consideration to the possibility that Patient B required repatriation by air ambulance to the UK. This was despite multiple entries in the event log that stated repatriation was needed, that Patient B's condition was deteriorating and an email from the host hospital saying that Patient B was not responding to treatment and required repatriation.

97. The Tribunal considered that, from 5/6 July 2017, Dr Nadal should have appraised himself of all of the relevant documentation, including the email from the hospital. The Tribunal acknowledged that Dr Nadal's evidence was that he had never seen the email. However, he accepted that he had looked at the event log and the medical reports. The event log contained multiple references to repatriation and concerns raised by Patient B's family about the treatment he was receiving and Patient B's lack of progress.

98. The Tribunal had regard to the entry from Dr G, which Dr Nadal had accepted appeared to suggest 'close monitoring' of Patient B was required. Since becoming involved in the case, Dr Nadal had made it clear that he was uncertain about what to do about Patient B. The Tribunal inferred that this uncertainty was largely borne of the fact that there was a lack of information being provided by the host hospital so the clinical picture for Patient B was unclear. On the one hand, there were indications from the event log that both Ms BB and Ms B were concerned about Patient B, it was recorded that Patient B was very unwell, that he was receiving sub-optimal treatment and that he required repatriation. However, on the other hand, Dr Nadal's evidence was that, as far as he was aware from the medical reports, Patient B was in a clinically competent private hospital and he was receiving treatment for his symptoms at that time, namely autoimmune haemolytic anaemia and there were inevitably risks associated with aeromedical transfer. In the Tribunal's judgment, if there was uncertainty in the mind of Dr Nadal as to the best course of action, this merely highlighted the need for him to actively monitor and obtain further information as to Patient B's treatment and progress, neither of which was done.

99. Dr Nadal's evidence was that it was only on 10 July 2017, after reviewing Patient B's case thoroughly on the evening of 9 July, that he realised he needed to *'break the impasse'* and ensure Patient B could be repatriated. Dr Nadal's evidence was that his action on 10 July was prompted by a lack of up to date information which he said his conversation with Ms BB filled on the morning of 10 July. He said it was after this conversation that he realised that he had to *'bite the bullet'* [and arrange air ambulance repatriation]. In the Tribunal's judgment, consideration of the potential need for an air ambulance repatriation could and should have been made much earlier.

100. Accordingly, the Tribunal was satisfied that Dr Nadal failed to monitor Patient B's treatment and progress at the host hospital and, as a result, his decision-making was inadequate.

101. The Tribunal found paragraph 2.c of the Allegation proved.

Paragraph 2.d.i

102. The Tribunal was required to determine whether Dr Nadal's ongoing decision-making in respect of the repatriation of Patient B was inadequate because he failed to discuss Patient B's case with his UK Consultant Haematologist, Dr C, to utilise the specialist advice being offered to him.

103. Dr Nadal accepted that, as a matter of fact, he had never communicated with Dr C.

104. The Tribunal had already determined that where there was a lack of information that was required to aid decision-making about possible repatriation, Dr Nadal had a duty to seek to obtain it. Despite having a responsibility for Patient B's case from 5/6 July 2017, there was no evidence that Dr Nadal had sought further information regarding Patient B beyond considering the updated Turkish medical report.

105. The Tribunal had regard to Dr C's letter, uploaded on 6 July 2017. It considered that even a cursory glance at the letter would have confirmed to Dr Nadal that Patient B had ***Refractory*** Autoimmune Haemolytic Anaemia (AIHA) [the Tribunal's emphasis], i.e. Patient B's AIHA was not responding to treatment. The Tribunal considered that, at the very least, this indicated Patient B's treating haematologist's view that Patient B was not receiving effective treatment. Given Dr Nadal's, albeit limited, knowledge of Evans Syndrome, he would have known that this could impact upon Patient B's chances of survival. This view would be

supported when, on 7 July, it was recorded in the event log that Patient B's condition was deteriorating.

106. With regard to Dr C's letter, Dr Nadal stated in his witness statement, the following:

> *'135. …A letter from* [Patient B]*'s consultant,* [Dr C]*, also came in. I think I read it by the end of 6th July, after it was brought to my attention by the Operations team. I see from the call log that* [Dr G] *read it the next day. I agreed with what* [Dr C] *said in the letter in that* [Patient B] *had a life threatening condition, and that he needed specialist care.* [Dr C] *made no reference to the specialist expertise that I knew was available, much closer to* [Patient B] *within Turkey. I would not have expected him to know about the availability of the specialism in Turkey, though as it was his field he might have done. This is really specialist knowledge.*
>
> *136. The letter was asking that* [Patient B] *be transferred back to UK, but it did not say how we could transfer* [Patient B] *back to the UK in his current very ill and unstable condition. Nor did it lead me to conclude that* [Dr C] *had considered in detail the risks of transfer to the UK by air as against the short road trip to the major public facility nearby…*
>
> *139. I did not telephone* [Dr C] *in reply to his letter. The letter did not ask for a reply or request a call. I had understood his request that* [Patient B] *be transferred back to Worthing. Over the years I have noticed that where a senior UK doctor becomes involved asking for a patient to be repatriated, it tends to make the family think that the only solution is transfer and continued treatment at home, when in many cases good treatment is available locally. It may inadvertently or even unconsciously entrench harmful attitudes in that the impression may be given, perhaps by a clinician less familiar than I am with other healthcare systems and their quality, that UK facilities are somehow inevitably better than those available locally, which is by means inevitable, though of course sometimes it may be the case.'*

107. In his conversation with Ms BB on 10 July 2017, Dr Nadal said about Dr C's communications:

> *'the only thing is he did send us an email that was extremely unhelpful in a sense it told us what we should be doing and that is very unhelpful, what is helpful is for him to tell us a bit more about* [Patient B] *and he told us nothing so that's what I would*

describe as a well intention[ed] *but completely unhelpful email I mean you know especially coming from the Worthing hospital because with all respect to the dignity of Worthing hospital it is not a centre of excellence for auto immune disease or haematology or anything at all…'*

108. Dr Nadal's criticism of Dr C's letter went further in his oral evidence. He said his *'heart sank'* when treating UK doctors sought to communicate with him about their patients who had fallen ill and who required treatment for their condition. It was Dr Nadal's evidence that the letter from Dr C told him everything that he knew already and, in terms, that there was nothing further with which Dr C could assist at that time. Dr Nadal said that the most useful thing Dr C could have done was to send a letter to the host hospital with information about Patient B's condition. Dr C had done this, although Dr Nadal may not have appreciated this at the time.

109. Dr Nadal was consistently dismissive of the attempted input of Dr C. Dr Nadal chose to reject the letter on the basis that it was simply requesting a return to Worthing rather than recognising that this was an opportunity to gain useful specialist advice on Evans Syndrome and Patient B's treatment needs for what was a life threatening condition.

110. The Tribunal had regard to the facts to which Dr Nadal should have had regard at the time he read Dr C's letter:

- He, Dr Nadal, was not a haematologist
- He, Dr Nadal, lacked the knowledge or experience to form a view as to Patient B's treatment needs
- Evans Syndrome is a very rare haematological condition;
- Patient B's UK treating haematologist, Dr C, as a Consultant Haematologist had specialist knowledge of Patient B's condition and he was Dr C's patient;
- Patient B's treating haematologist, Dr C, was of the view that Patient B was experiencing refractory autoimmune haemolytic anaemia and was said to be 'somewhat stable' but seriously unwell and needed to be repatriated to the UK for treatment;
- The host hospital had refused to look at Patient B's UK hospital records and were not treating Patient B as aggressively as he would have been treated in the UK (as recorded on the event log);

- Patient B was not, at the time, in a hospital specialised in haematological diseases and haematological input was limited to advice over the telephone from a haematologist at a different hospital;
- Patient B's condition was deteriorating.

111. The Tribunal concluded that it was evident that Dr C was in a position to provide relevant and useful input in relation to Patient B's treatment needs and could have assisted Dr Nadal in his decision-making concerning repatriation. Dr C's letter made it plain that Dr C was willing and able to provide specialist advice and in the Tribunal's judgment, he was an obvious source from whom to seek such information.

112. The Tribunal found it difficult to comprehend how Dr Nadal considered Dr C's letter to be *'unhelpful'* and considered that this may have been as a result of his apparent general dismissal of the views of UK treating clinicians who seek to offer advice with regard to their patients who are seeking repatriation. Furthermore, the Tribunal considered that, if Dr Nadal had reason to question the opinion that Dr C was expressing in his letter, this would have been all the more reason for him to discuss Patient B's case with Dr C rather than to dismiss the letter out of hand.

113. The Tribunal noted that it was Dr Nadal's evidence that he intended to contact Dr C after a decision had been made to repatriate Patient B to the UK, a decision made on 10 July 2017. However, Dr Nadal accepted that he did not contact Dr C at anytime. The Tribunal did not find any evidence to support the suggestion that Dr Nadal had ever intended to contact Dr C other than his mentioning in his call with Patient B's wife on 10 July 2017 that he *'might have a word'* with Dr C.

114. Accordingly, the Tribunal concluded that Dr Nadal had failed to discuss Patient B's case with Dr C to utilise the specialist advice being offered to him and he should have done so.

115. Therefore, the Tribunal found paragraph 2.d.i of the Allegation proved.

Paragraph 2.d.ii

116. The Tribunal was required to determine whether Dr Nadal's ongoing decision-making in respect of the repatriation of Patient B was inadequate because he failed to discuss Patient B's case with an air ambulance company for advice about the risks of repatriation.

117. The Tribunal acknowledged that it was not alleged that Dr Nadal had made a decision that was necessarily wrong in respect of Patient B. He is criticised for failing to obtain adequate information to properly inform the decisions that he did make.

118. The Tribunal also acknowledged that Dr Nadal's role was advisory. Any decision about repatriation had to be taken by the insurer. However, the Tribunal was satisfied that the advice Dr Nadal gave to his insurer client would be a key consideration as to whether or not air repatriation would be authorised by the insurer.

119. The Tribunal had regard to the evidence of Dr Q as to the risk of aeromedical repatriation generally, and in particular, regarding patients who are haemolysing [the process by which the body destroys red blood cells] and have a low and/or fluctuating haemoglobin level.

120. Dr Nadal's evidence was that, in the case of Patient B, he would have sought advice from an air ambulance company at the 'appropriate time'. In the case of Patient B, Dr Nadal said this was following his conversation with Ms BB on 10 July 2017.

121. Dr Nadal's evidence was that because of his experience, he already knew that there were risks associated with aeromedical repatriation. Further, he stated that, when considering the risk of repatriation, any requirement to seek advice from an air ambulance company, would only arise in circumstances where the decision had been taken that a patient needed to be repatriated. Therefore, it was only from 10 July that Dr Nadal considered that it was necessary to seek advice from an ambulance company. The Tribunal accepted Dr Nadal's evidence in this regard. That was not to say that Dr Nadal's decision not to repatriate earlier was the right one, neither was it to say that he should not have considered repatriation earlier. However, the Tribunal concluded that, given the general risks of aeromedical repatriation were well known to Dr Nadal, there was no reason to seek further advice as to the risks unless and until the decision had been made that Patient B's best interests lay in repatriation to the UK.

122. Therefore, the Tribunal determined that Dr Nadal did not in the circumstances of Patient B's case have a duty to discuss his case with an air ambulance company for advice about the risks of repatriation until a decision to repatriate had been taken.

123. The Tribunal found paragraph 2.d.ii of the Allegation not proved.

Paragraph 2.e.i and ii

124. The Tribunal was required to determine whether Dr Nadal's ongoing decision-making in respect of the repatriation of Patient B was inadequate because he failed to pursue early aeromedical repatriation having regard to Patient B having a complex, rare and life-threatening condition that required specialist care and that the necessary clinical expertise was not available to Patient B at the host hospital.

125. The Tribunal did not accept Mr Geering's submission that 'early' in paragraph 2.e of the Allegation must refer to repatriation in the 'early' stages of Patient B's illness, i.e. at a time before Dr Nadal had any responsibility for Patient B's case.

126. The Tribunal determined that 'early' referred to pursuing aeromedical repatriation at the earliest opportunity. For the reasons previously stated, the Tribunal considered that Dr Nadal had a responsibility in relation to Patient B from 5/6 July 2017, following him having been made aware of the case by Dr G. From this time, the Tribunal considered that Dr Nadal had a duty to make a timely decision on whether to repatriate Patient B. Dr Nadal's evidence was that, as at 5/6 July, he did not know what to do and the event log suggests that the only decision made at this time was to '[close] *monitor* [the case]'. Further, Dr Nadal stated that he did not decide to repatriate Patient B until 10 July 2017, by which time it was too late to effect the repatriation and Patient B died on 12 July 2017.

127. The Tribunal noted that Dr Nadal had accepted, as a matter of fact, that Patient B had a complex, rare and life-threatening condition, and that he had at least suspected from 5 July 2017, that there was not the necessary clinical expertise at the host hospital to treat Patient B's condition. He had also accepted he knew that there was a high mortality rate for patients with Evans Syndrome, even for those patients who were only exhibiting symptoms of AIHA (one of the components of Evans Syndrome).

128. The Tribunal also had regard to what Dr Nadal knew or ought to have known on 5/6 July 2017, which included:

- Ms BB had reported that the Yucelen hospital was giving 'under par' treatment, his treatment at Yucelen was much less aggressive than he would receive in the UK and Patient B was now *'captive*' in the hospital;
- Patient B was haemolysing and in need of constant transfusions;

- The doctors at the Yucelen hospital had a history of being non-communicative and despite the efforts of Patient B's family, the treating doctors had not been forthcoming in providing medical reports;
- Ms B had provided the treating doctors at Yucelen with Patient B's notes from his UK GP advising what treatment Patient B needed but the treating doctor had refused to read them or make contact with the UK GP;
- Ms B had expressed her concern that Patient B was not getting the treatment he needed;
- An email had been received from the Yucelen hospital with a medical report in Turkish attached, the email addressed to the insurer requested air ambulance repatriation.

129. The Tribunal also inferred from the facts of which Dr Nadal would have been aware at this time, that Dr Nadal should have known that both Patient B's wife (Ms BB) and his mother (Ms B) would have insight into and knowledge of the management and history of Patient B's pre-existing and rare condition and their knowledge could have been useful in his decision-making.

130. In these circumstances, the Tribunal considered that when Dr Nadal had a responsibility for Patient B's case, on 5/6 July, he had enough information to know that early repatriation should be given active consideration.

131. The Tribunal accepted Dr Nadal's evidence that the early stages of AIHA could be managed by a non-specialist. However, it was of note that Patient B had been under the specialist care of a Consultant Haematologist in the UK for many years and the relapses in his condition had been managed well. Furthermore, whilst Dr C acknowledged that the treatment for early stages AIHA could be relatively straightforward, it would depend on the nature of the 'flare up'. However, haemolysis can take a course that requires further intervention and that this would require specialist expertise.

132. The Tribunal also had regard to the letter emailed by Dr C's secretary, which was uploaded on 6 July 2017 and which Dr Nadal accepted he had read on that day. The letter indicated that the host hospital did not have the necessary clinical expertise to treat Patient B.

133. The letter from Dr C stated that the host hospital was not specialised in haematological diseases and indicated that there was only some input from a remote

haematologist. The Tribunal was satisfied that it could infer from that and other information that there were no specialists in haematology on site at the host hospital. Indeed, Dr C confirmed that he had spoken to a cardiologist at the Yucelen hospital with regard to Patient B, he had considered that this doctor lacked the necessary experience to treat Patient B and that it had been Dr C's advice that Patient B should be repatriated once he had stabilised. The Tribunal did not accept that, given the high fatality rate for Evans Syndrome, even for those patients who were only exhibiting symptoms of AIHA, that reactive telephone advice from a distant haematologist was sufficient in the management of Patient B's condition.

134. The Tribunal did not consider that Dr Nadal, given his lack of expertise, could rely on his own assessment of the adequacy of Patient B's treatment and his response to it. Not only did Dr Nadal lack sufficient expertise, he did not have sufficient information from which he could safely conclude that Patient B was receiving adequate or effective treatment. In particular, Dr C had referred to Patient B's condition being refractory, meaning it was not responding to treatment and, in the Tribunal's judgment, required specialist input. There was, at the relevant time, no information available to Dr Nadal to suggest that the treating doctor(s) responsible for Patient B's care at the host hospital had experience of treating complex haematological conditions, which in the case of Patient B was refractory, i.e. resistant to treatment.

135. Furthermore, the Tribunal considered that it was telling that when speaking to Ms BB on 10 July 2017, Dr Nadal had said of the doctors at the Yucelen hospital *'…*[they] *probably have no idea what they are doing…'* and *'they don't seem to me to be making things better, they are making them worse I fear'*.

136. The Tribunal determined, if Dr Nadal was not going to pursue an early aeromedical transfer, it would be incumbent upon him to ensure that Patient B was transferred to a hospital, whether public or private, that had the appropriate expertise. In the Tribunal's judgment, Dr Nadal's belief that there existed public hospital facilities in Turkey at which Patient B could receive appropriate specialist treatment was an insufficient basis for Dr Nadal not to pursue early aeromedical repatriation absent a clear indication that there was a local hospital capable, and willing, to admit Patient B for the specialist treatment he required.

137. The Tribunal determined that, in the light of the information provided by Dr C, the concerns expressed by Patent B's family and the lack of haematological input at the host hospital, there was insufficient basis for Dr Nadal to conclude that Patient B was receiving adequate treatment at the host hospital. If Dr Nadal was not to advise repatriation, he should

have satisfied himself Patient B would be transferred to a facility in Turkey where he would receive such treatment. Further, given what Dr Nadal knew about the host hospital's approach to insured tourists, he should have been sceptical of the reasons they gave to explain their reluctance to transfer Patient B and considered taking steps to repatriate him but there is no evidence to suggest that he did so.

138. Further, with regard to the issue of why it had not been until 10 July 2017 that Dr Nadal had advised repatriation, during the course of Dr Nadal's evidence he was pressed about what had changed between 5 and 10 July 2017 to prompt his decision on 10 July to advise for a repatriation. Initially he appeared unable to identify what he had believed had changed. However, following a short adjournment, he indicated that he had now recalled, that it was seeing the entry on 9 July at 17:33, where Ms B said she believed her son would die, that had prompted his decision. Dr Nadal said that this was the first time that he had considered that the patient might die.

139. Dr Nadal's evidence was that it was this entry that led to his understanding of how dire the circumstances for Patient B had become and when he saw a reference to the possibility of Patient B dying that he knew he had to take action. The Tribunal did not accept that this was the first opportunity Dr Nadal had to take action because he had already done research about Evans Syndrome; he knew about the high mortality rates; he knew that concerns were being expressed by Dr C, Ms B and Ms BB about the care Patient B was receiving. Dr Nadal should have known that Patient B was at a high risk of death. The Tribunal did not accept that he needed to read the event log entry at 9 July 2017 at 17:33 to appreciate the need for urgent action.

140. The Tribunal considered it surprising that Dr Nadal's evidence was that he became alert to Patient B's life being at risk and his decision to *'bite the bullet'* came as late as 10 July 2017 and only following his conversation with Ms BB. This was compounded by his previously expressed dismissive attitude towards the reliability of information provided by patients' relatives. However, if this was correct, the Tribunal concluded that this served only to illustrate how little consideration Dr Nadal had given to the need to pursue an early aeromedical repatriation.

141. The Tribunal determined that Dr Nadal had failed to pursue early aeromedical repatriation despite the evident need to do so. It determined Dr Nadal had failed because he did not take any meaningful action until 10 July 2017, by this time, as subsequent events

were to prove, any opportunity that there may have been for a successful repatriation had been lost.

142. The Tribunal found paragraph 2.e.i and 2.e.ii of the Allegation proved.

Paragraph 3.a

143. The Tribunal was required to determine whether, from 5 July 2017 onwards, Dr Nadal's care of Patient B was inadequate because he failed to ensure the telephone calls from Patient B's family were returned in a timely manner.

144. The premise of this paragraph of the Allegation, and Dr Q's criticism of Dr Nadal in this respect, was that there had been more than one request for Dr Nadal to return calls from members of Patient B's family.

145. In considering Dr Nadal's duty in respect of returning calls, the Tribunal determined that in the specific circumstances of Patient B's case, given its seriousness, if Patient B's family were seeking to speak to Dr Nadal, he had a responsibility to ensure that their calls were returned in a timely manner, even if they were not returned by him personally. The Tribunal accepted that it was primarily the call handlers and case handlers at EAF who interacted with policyholders' families.

146. Therefore, from the point at which Dr Nadal had responsibility for Patient B's case (5/6 July 2017), the Tribunal determined that he had a responsibility in terms of communicating with Patient B's family and ensuring their calls were returned in a timely manner. In the Tribunal's judgment, it would have been a failure on Dr Nadal's part to ignore call back requests of which he had been made aware. Plainly, if Dr Nadal was not aware that there had been such a request, he could not be properly criticised for failing to ensure the call was returned.

147. With regard to requests made for call backs made by members of Patient B's family, the Tribunal had no evidence that Dr Nadal had been told, or otherwise been made aware, of such requests beyond that which was evident, or could be inferred from, the contents of the event log. Having had regard to the event log, the Tribunal accepted that there had only been one call from Ms B that had not been returned. She called at 17:33 on Sunday 9 July 2017. The Tribunal accepted, as was the evidence of Dr Nadal, that he had fully read up on Patient B's case and fully appraised himself of all the detail. Dr Nadal's first entry in the event log,

that confirmed that he had read the file was at 21:53 on 9 July 2017. The following day, 10 July, Ms BB called EAF at 10:39, and was put through to speak to Dr Nadal. The Tribunal considered that this evidence, at its highest, showed that there had been only one call from which it could be inferred that Dr Nadal had been made aware and therefore one which he had a responsibility to ensure was returned in a timely manner and not multiple calls as had been alleged.

148. The Tribunal considered that it was not appropriate to invite amendment of paragraph 3.a to allege a single call, bearing in mind that the premise upon which Dr Q's opinion had been based, i.e. multiple calls. Dr Q had not been cross-examined on the basis of a failure to return a single call, nor had Dr Nadal advanced his defence on this basis. Therefore, the Tribunal considered that any consideration of an amendment to the Allegation made at this late stage could cause injustice and was therefore inappropriate.

149. The Tribunal found paragraph 3.a of the Allegation not proved.

Paragraph 3.b

150. The Tribunal was required to determine whether, from 5 July 2017 onwards, Dr Nadal's care of Patient B was inadequate because he failed to return Dr C's telephone calls.

151. The Tribunal considered that Dr Nadal had a duty to return any calls from Dr C of which he had been made aware from the time of his taking responsibility of the case from Patient B. Indeed, Dr Nadal accepted that he should return calls from another doctor, if only, as a matter of professional courtesy.

152. The Tribunal accepted the evidence of Dr C that he had telephoned EAF in an attempt to speak with a member of the Medical Team. It was his evidence that he made calls to EAF before he sent the letter sent 5 July via his medical secretary.

153. However, although the Tribunal accepted that Dr C had most likely been told by a call handler that a member of the Medical Team would return his call, there was no reference on the event log that recorded any telephone calls made to EAF from Dr C, much less was there any reference to a request for Dr Nadal to return any call from Dr C and there was no evidence to suggest that any messages had been passed to the Medical Team requesting a call back for Dr C.

154. Further, although the Tribunal found that Dr Nadal had read the letter from Dr C on or about 6 July 2017, this letter did not mention that Dr C had made calls which had been unanswered.

155. In these circumstances, there was no evidence from which it could be inferred that Dr Nadal had been told, or had otherwise been made aware, that Dr C had been trying to call him. Accordingly, Dr Nadal could not be criticised for having failed to return any calls made by Dr C.

156. The Tribunal found paragraph 3.b of the Allegation not proved.

Paragraph 4

157. The Tribunal was required to determine whether on 10 July 2017, Dr Nadal's communication with Patient B's family was inappropriate.

158. In considering the duties of a registered medical practitioner in respect of communication, the Tribunal bore in mind paragraphs 4, 31, 32 and 33 of GMP:

> ***4*** *You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.*
>
> ***31*** *You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> ***32*** *You must give patients[20] the information* ***they want or need to know in a way they can understand****. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
> [The Tribunal's emphasis]
>
> (Footnote 20) *Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.*

> ***33*** *You must be* ***considerate to those close to the patient and be sensitive and responsive in giving them information*** *and support.*
> [The Tribunal's emphasis]

159. Whilst acknowledging that Patient B had no doctor/patient relationship with Dr Nadal in a clinical sense, the Tribunal considered that Dr Nadal did, in accordance with GMP, have a duty to communicate effectively, and appropriately, with Patient B's family.

Paragraph 4.a

160. The Tribunal was required to determine whether on 10 July 2017, Dr Nadal's communication with Patient B's family was inappropriate in that his attitude was uncaring *and* unprofessional.

161. The Tribunal first considered the context in which Ms BB's call to EAF was being made, and why her call was transferred to Dr Nadal for her to speak to him directly.

162. Ms BB was a distraught spouse, concerned about what she believed to be the inadequacy of her husband's treatment and care, and by 10 July 2017, as Dr Nadal knew, she was in fear that her husband might die if he was not urgently repatriated. Ms BB and her mother-in-law Ms B had worked collectively to get the insurance company 'on side' and to seek assistance in addressing their concerns about the host hospital's treatment of Patient B. They had advised EAF that he was not responding to treatment and that his condition was deteriorating. It was that desperation that prompted Ms BB to call EAF again on 10 July 2017 and her distress was such that the call handler requested Dr Nadal speak to her directly. Dr Nadal said this was something he rarely did but he felt compelled to following his evaluation of the case the night before and because he had been urged to do so by the call handler who had taken Ms BB's call. Ms BB was seeking intervention from the insurer to secure a transfer for Patient B so that he could receive necessary and urgent treatment.

163. The Tribunal noted that Dr Nadal's call with Ms BB lasted almost 30 minutes. It also recognised that Dr Nadal had not had time prior to his conversation with Ms BB to prepare for it. However, the call should not have come as a surprise to Dr Nadal because he had read Patient B's case file the evening before and, the previous day, he had recorded that he intended to return Ms B's call, and so he should have been anticipating speaking to a member of Patient B's family. Therefore, the Tribunal did not accept that Dr Nadal would have been wholly unprepared to speak with a member of Patient B's family.

164. The Tribunal had seen and heard Dr Nadal give evidence for over a week. In that time, the Tribunal had seen first-hand that he had an evident tendency to anticipate questions and to interrupt with his view of what he thought was being asked of him. He frequently provided detail on matters that were irrelevant and often digressed from the point in issue. Throughout Dr Nadal's evidence, there were occasions when Dr Nadal's own counsel interjected (appropriately) to remind Dr Nadal to address the question that was being asked, as did the Tribunal.

165. The Tribunal recognised that in considering the appropriateness or otherwise of Dr Nadal's communication with Ms BB, it needed to be mindful that not all people communicate in the same way. The Tribunal was also mindful that a margin of appreciation was required to reflect the fact that people have different styles of communication. Furthermore, the Tribunal considered the fact that a conversation with a member of a patient's family might include some irrelevancies, that does not necessarily render the doctor's communication inappropriate. It is a matter of fact and degree that the Tribunal must consider.

166. The Tribunal had regard to how Ms BB's conversation with Dr Nadal progressed and made allowance for his propensity to give long and discursive answers.

167. The Tribunal also noted the evidence that Dr Q gave in respect of this paragraph of the Allegation. The Tribunal did not consider that it was particularly assisted by his opinion because the Tribunal found it was able to form its own judgment with regard to the appropriateness of Dr Nadal's communication with Ms BB.

168. The Tribunal acknowledged that paragraph 4.a of the Allegation related to the whole of Dr Nadal's conversation with Ms BB, in that the conversation was alleged to be, uncaring and unprofessional in its totality.

169. The Tribunal, having considered the whole of the conversation, determined that there were comments made by Dr Nadal which were unnecessary and might have been regarded as uncaring and/or might have been regarded as unprofessional. However, having regard to the totality of the conversation, its content and its context, the Tribunal did not consider that the conversation could be categorised as an uncaring and unprofessional conversation in its totality.

170. In particular, the Tribunal had regard to Ms BB's evidence about how she had perceived Dr Nadal's attitude during the conversation. It reminded itself of Ms BB's answer to a question from the Tribunal in which she said:

> *'Q Finally, at the end of the conversation with Dr Nadal what did you feel? Did you feel reassured at the end of the conversation? You have said throughout that he had been very polite, courteous etc. But what was your final impression at the end of that conversation?*
>
> *A I felt reassured because I felt somebody was going to actually do something and help him.'*

171. In these circumstances, the Tribunal concluded that Dr Nadal's communications with Ms BB were not inappropriate because it did not find that his attitude had been uncaring and unprofessional throughout their conversation.

172. The Tribunal found paragraph 4.a of the Allegation not proved.

Paragraph 4.b

173. The Tribunal was required to determine whether on 10 July 2017, Dr Nadal's communication with Patient B's family was inappropriate in that he gave advice about blood transfusion which served no useful purpose.

174. The Tribunal had regard to what Dr Nadal had said about blood transfusion in his call with Ms BB. He said:

> 'MJN: *Do you know if they, just let me ask you a question, do you know if they are giving him cross match blood or uncrossed matched.*
>
> [Ms BB]: *yes, they are, yes they are cross matching it.*
>
> MJN: *Yeah well that's what's wrong, it's one of the very very rare conditions, I mean I'm not a haematologist but the problem is he's creating antibodies to his own red blood cells as well as his own platelets and its counter intuitive this but it's one of the conditions in which you have to consider deliberately giving poorly matching blood because you know that the antibodies are to his own type of blood so if you give more*

of the same then he is going to have a particularly effective attack against those so you're just going to get more hemolysis that where the red blood cells burst that affects kidney function and all sorts of things as you know I'm sure.

[Ms BB]: *Yep*

MJN: *So, what you actually do is you give non-cross match blood, you know I wouldn't ever tell anybody to do this but if you read the text books…*

[Ms BB]: **Laughs**

MJN: *So, no so the point is the strategy is therefore we could give non-cross matched blood you've got a lesser antibody response to that because you haven't yet learnt what particular anti or your immune system hasn't yet learnt which particular antigens you've got so curios enough it was you'd never normally do it in this condition, it's one of the things you should consider doing. Anyhow it's a really difficult problem this because people often think that air ambulances because of the word ambulance is safe but they are not and I wouldn't want to upset you by telling you all the reasons why they are not safe but the fact is you got to jolly well make sure that when you put somebody in an air ambulance you're going to do more good than harm, I'm distressed by the fact he is in this particular private clinic because there is a good public hospital in Mugla and it's not a major university hospital but it is the largest regional hospital and they are more likely to have the know how to treat this because I do get the impression, these doctors probably have no idea what they are doing, but,*

[Ms BB]: *yes, I get that impression too.*

MJN: *they have given anti CD20 which is a particular monoclonal antibody against a certain type of lymphocyte B lymphocyte, so it's on all B Lymphocytes and they help generate immune responses so your supressing the immune response and that is actually sensible. So, I am not at all happy about this but I think we are just going to have to bite the bullet actually and send an air ambulance to get him…'*

175. The Tribunal also had regard to Ms BB's answers in cross-examination:

'Q That tells you one of two things. Either he had that knowledge all along or if he didn't he has gone away and looked it up, yes?
A Yes.

Q That would be reassuring wouldn't it?
A Yes.

Q This is not a man who was indifferent to your husband's condition. Although he has never heard of the condition he has actually bothered to look it up and find out how it is treated, yes
A Yes.

Q You would praise him for doing that wouldn't you?
A Yes.

Q You would expect him to do that wouldn't you?
A Yes.

Q The more reassurance he can give you that he knows what Evan's Syndrome is the more reassured you are that your husband is not being ignored but rather that somebody has thought carefully about it, yes?
A Yes.

Q That is important isn't it?
A Yes.'

176. It was Dr Nadal's evidence that his purpose, in raising the transfusion of blood that had not been cross-matched, was not to give treatment advice but because he wanted to reassure Ms BB that he had looked into Patient B's condition. Dr Nadal also wanted to confirm that her assessment of Patient B's treatment was correct insofar as he said: *'These doctors probably have no idea what they're doing'*.

177. In this regard, having considered the conversation between Ms BB and Dr Nadal, as well as her oral evidence, the Tribunal accepted Dr Nadal's evidence. His comments about blood transfusion had served a purpose and that was to reassure Ms BB, which she confirmed he had done.

178. The Tribunal found paragraph 4.b of the Allegation not proved.

Paragraph 4.c.i and 4.c.ii

179. The Tribunal was required to determine whether on 10 July 2017, Dr Nadal's communication with Patient B's family was inappropriate in that he shared an unprofessional opinion that Dr C's letter, dated 5 July 2017, was very unhelpful.

180. It was also required to determine whether Dr Nadal's had shared an unprofessional opinion about the ability of Worthing Hospital to manage Patient B's condition.

181. The Tribunal considered both paragraphs of the Allegation together because they were captured in the same comment of Dr Nadal's.

182. The Tribunal had regard to the context in which Dr Nadal told Ms BB that Dr C's letter was unhelpful. She had tried to bring him back onto the topic of speaking with Dr C about Patient B's condition and in response Dr Nadal had said:

> *'the only thing is he did send us an email that was extremely unhelpful in a sense it told us what we should be doing and that is very unhelpful, what is helpful is for him to tell us a bit more about* [Patient B] *and he told us nothing so that's what I would describe as a well intention but completely unhelpful email I mean you know especially coming from the Worthing hospital because with all respect to the dignity of Worthing hospital it is not a centre of excellence for auto immune disease or haematology or anything at all…'*

183. The Tribunal concluded that Dr Nadal's sweeping and dismissive comments about Dr C's letter and Worthing Hospital were plainly unprofessional. He categorised Dr C's letter as *'extremely unhelpful… very unhelpful… especially coming from Worthing Hospital…'*

184. The Tribunal considered that Dr Nadal's comments were pejorative of Dr C, his letter, and the ability of Worthing Hospital to treat Patient B. Dr Nadal showed discourtesy to Dr C and Worthing Hospital despite his lack of knowledge about either. Dr Nadal's comments had the potential to undermine Ms BB's confidence and cause her further distress as the comments Dr Nadal made denigrated the doctor and the hospital that had a responsibility for her husband's care.

185. Mr Geering had submitted that Dr Nadal's criticisms had not been unqualified and that Dr Nadal had gone on to say, a short while later in the conversation: *'I'm just saying that opinions without information are not very useful… no man's opinions are better than his information and so with all respect to* [Dr C] *is that Worthing hospital is I'm sure very functional and they do their best for everybody but it's not a major centre of excellence and I can tell you something if you go Ankara you will find a greater degree of expertise on this condition that you have got at Worthing hospital which is why researching institutes are working on it and things you know, so they really do, there are centres of excellence in Turkey which are world class…'*

186. However, the Tribunal noted that Dr Nadal's qualification of his initial criticisms of Dr C and Worthing Hospital had been prompted by Ms BB telling Dr Nadal that she also worked at Worthing Hospital and that she knew Dr C quite well.

187. The Tribunal considered that the first observation made by Dr Nadal about Dr C and Worthing Hospital was inappropriate and unprofessional and that it remained so despite his subsequent endeavour to dilute his criticism upon learning of Ms BB's connection with both Dr C and the Worthing Hospital.

188. The Tribunal determined that it was plainly inappropriate for Dr Nadal to make disparaging comments about Dr C's letter and Worthing Hospital, particularly having regard to the circumstances of Ms BB's call to him.

189. The Tribunal had observed during the course of Dr Nadal's evidence that he had a marked tendency to dismiss the views of people whose opinions did not agree with his own. Having considered the extensive evidence in this case, the Tribunal formed the distinct impression that Dr Nadal was a person who had a tendency to form fixed views and which he stuck to even when presented with evidence that undermined his view. The Tribunal considered that it was this trait that often led to Dr Nadal only having regard to information that supported his beliefs or assumptions and ignoring that which did not, in what might be described as confirmation bias.

190. For example, it was a theme of Dr Nadal's evidence that he would only in exceptional circumstances advise repatriation to the UK of a patient from a country which had a developed healthcare system because, in his view, suitable healthcare would always be available and accessible in the host country. This was a view that he would stick to even where there were facts available that would suggest repatriation to the UK was more

appropriate. A further example was that Dr Nadal rejected the notion that he should consult with medical practitioners responsible for a patient's care in the UK because they would always recommend repatriation regardless of whether this was in the patient's best interests and that they would have no knowledge of the risks associated with repatriation or the availability of healthcare provision in the host country. The Tribunal accepted that this may be the case in some instances but did not accept that it must necessarily be the position in all cases as Dr Nadal portrayed. Dr Nadal was similarly dismissive of the views of insured patients, or their families, seeking repatriation to the UK on the basis that they all had a *'homing instinct'* and would always wish to access medical treatment in the UK even when it was in the best interests of the patient to remain in the host country. Whereas, the Tribunal accepted that patients and/or their family members may naturally wish the patient return to their home country for treatment, this was not a reason to ignore the fact that they may have other perfectly valid reasons for seeking repatriation.

191. The Tribunal found paragraph 4.c.i and 4.c.ii of the Allegation proved.

Patient D - Chronology

192. The Tribunal had regard to the chronology it set out in Annex C. Since that chronology had been produced, the Tribunal had been furnished with a more complete copy of the EAF event log. Accordingly, the Tribunal considered the chronology of Patient D's case afresh, taking into account the event log and other contemporaneous documentary evidence. The following are extracts from the more complete copy of the event log, which were taken into account by the Tribunal, which had added a commentary where relevant:

> 11 February 2018
>
> Event Log – 20:35 –*…'Call from pax* [Policyholder i.e. Patient D] *daughter , pax has had a heart attack , he is in General hospital Arricefe. no fax or email for hospital but telephone taken…*
>
> 12 February 2018
>
> Event Log – 08:53 – *Call to* [Ms D] *pax is still very ill*
>
> Event Log – 10:43 – [Ms D] *called in to advise that if we fax the CF* [Claim Form] *to the hospital they will send us the MR…*

Event Log – 15:34 – *Document Uploaded: MR* – [Patient D].*pdf*

> [Medical report, dated 12 February 2018, indicated that Patient D had been admitted to Hospital Dr José Molina Orosa Arricefe with a heart attack. Under the heading *'Clinical Judgement'*, it said]:
>
> *- ACUTE CORONARY SYNDROME WITH ST-SEGMENT ELEVATION IN PATIENT WITH PROBABLE CHRONIC CARDIOPATHY. KILLIP III. TIMI 5 (HIGH RISK). GRACE 188 (HIGH RISK). CRUSADE 48 (HIGH RISK).*
> *- PROBABLE RESPIRATORY TRACT INFECTION AS TRIGGER*
> *- FIRST DEGREE AV BLOCK*

Event Log – 15:39 – [Ms D] *called in to say that hospital are saying pax needs to come home via AA or stay a long time there – have tasked MT to comment*

13 February 2018

Event Log – 00:26 – *Progress changed from None to MR ; Pax admitted for STEMI (probably chronic cardiac disease) high risk chest infection Pax on oxygen… the patient will need possible transfer to main island (Gran Canaria) for cath lab . awaiting medical updates*

Event Log – 00:30 – *Completed Task… pls MR on file in Spanish – hospital are saying to repat via AA or stay for 3 months*

19 February 2018

Event Log – 18:33 – [Ms D] *called advised PAX is in a cardiac ward…*

20 February 2018

Event Log – 15:02 – *Called the hospital and spoke with Oncology ward with the TD* [Treating Doctor] [Dr O]*, pax need an ambulance to transfer to the UK pax needs operation catheterism and need to wait 1 month for the operation TD mentioned that pax need to come home to have the operation in the UK TD will send the MR to us*

Event Log – 16:27 – *CAll to hospital to chase MR – I was put through to the oncology department. PAX is progressing – PAX has a lung infection and has had an MI* [Myocardial Infarct]. *PAX has 40% Dysfunction of the heart. The hospital will fax us a MR to ops tomorrow morning urgently. The hospital thinks PAX may need an AA.*

[Throughout the event log there is reference to the oncology ward, the Tribunal considered that it was likely that this should have been a reference to a cardiac ward.]

21 February 2018

Event Log – 13:50 – *Call from* [Ms D]*… mentioned that we have MR but only 2 pages and will contact the hospital to request the full MR but the 2 pages we will pass to our MT hopefully is sufficient…*

[The Tribunal had sight of the two pages of this medical report, dated 20 February 2018. This report appeared to be incomplete to the extent that there was no completed section as to 'progress' or 'clinical judgement' as there had been on the completed medical report, dated 12 February 2018 which the Tribunal had also seen. Whilst later entries in the event log suggested a completed medical report dated 20 February 2018 was provided, the Tribunal could not identify this complete report within the exhibited documents.]

Event Log – 15:52 – *Reassign task to* [Dr G]

Event Log – 16:35 – [Ms D] *called in chasing MT update as she is trying to plan…*

22 February 2018

Event Log – 09:48 – *Completed Task – R – MR attached 2 pages only have pass to our MT if no sufficient full MR needed to be requested plz UD* [Update] *pax daughter* [Ms D]

Event Log – 14:30 – *Called from* [Ms D] *requesting UD she wants also to know about the complain she made as she hasnt heard anything as there is no sense of urgency about her father's case…*

Event Log – 14:45 – [Ms D] *would like a call… to put a complaint in. She wants me to tell her when pax will be flying exactly. I cannot do this as we are waiting for MT review.*

Event Log – 15:37 – [Dr G] *said he needs full MR to act – CAll to hospital to chase MR – No answer.*

23 February 2018

Event Log – 09:46 – *Call from* [Ms D] *in UK. An MR was received by us and was incomplete.* [Ms D] *complained this was not chased with the hospital.* [Ms DD] *(pax daughter out in Spain) has a full copy and will set t to us now so* [Dr G] *can complete his assessment*

Event Log – 17:12 – [Entry from Dr G] *Progress changed from None to Update MR ; ETT ; severe global ventricular dysfunction akinetic lateral inferior and posterior wall . Complete the atb* [antibiotics] *due to chest infection . TD suggested AA for cath lab.in UK Assessed case with MJN we both agreed that TD should complete the investigation and treatment under EHC agreement and then repat (when patient is safe) if the hospital do not have the facilities they need to transfer the to the main island (Gran Canaria) . Called daughter and explain the same reasons why we do not contemplate to repat on AA due to high risk . Called several times to hospital on call team availability only – they have a emergency unable to attend. Discussed case with* [case handler] *she will try to contact on call team and discuss our position , also the daughter will like to be updated .*

Event Log – 17:12 – *Completed Task – Full DMR now on file*

[Based on the content of these entries, the Tribunal was satisfied that it could infer that a complete medical report was uploaded between 09:46 and 17:12. The Tribunal also noted that this is the first entry in the event log that makes reference to Dr Nadal having any involvement in Patient D's case. The Tribunal had not had sight of the completed medical report. However, it considered that it was likely that the context of the 17:12 entry indicated that the treating doctor was advising that an air ambulance was needed in order for Patient D to undergo catheter lab angiography in the UK. Although, the Tribunal acknowledged that it was possible, in the light of the entry of 24 February 2018 at 10:32 (see below) that the report had contemplated a transfer to Gran Canaria.]

24 February 2018

Event Log – 10:32 – *Call to* [Ms D], [Ms DD] *is flying back today leaving* [Patient D] *on his own in hospital. She has read on the report that the patient is to be transferred to Gran Canaria. I said we were chasing this point with the hospital. I explained it was an inter-hospital arrangement and we could not influence it much but we would try on Monday. She was upset and said we did absolutely nothing and we were obviously completely understaffed. I said we would continue to chase hospital…*

26 February 2018

14:11 – Email from Ms D to EAF:

> *Good afternoon. Please can someone call me and update me on what attempts have been made to arrange for my father to receive the tests and treatment he needs since Friday.* [EAF Employee] *gave me an update Saturday Morning – she finally (after some pressure) advised the following*
>
> - *You finally have the full medical report that was requested early last week – but only because I emailed to you – you didn't chase it even though you knew it was incomplete.*
> - *You are not going to fly him home in an air ambulance, you felt it was too dangerous.*
> - *You want him to go to Gran Canaria for tests and possibly a stent but advised that there were no beds in available – you are not responsible for this apparently – it's the hospitals job but you can't see to get hold of anyone to organise it.*
>
> [Patient D] *is now all alone as my sister has flown back to the UK and very distressed. Little or no one in the hospital speaks English so he has no idea what's happening.*
>
> *I have been trying to get and update for over a week so we can make plans to be with him but until you make your minds up and get something sorted we can't plan anything.*

I have contact number for the ward…

I have called twice today and no one has called me back. I am at my wits end. I suffer with stress and anxiety, as does [Patient D] *this situation is doing nothing for his or my health.*

Event Log – 17:43 – *Call* [Ms D]*, she would like to know when pax will be transfer to Gran Canaria. Explained is the hospital's duty of care to arrange it, she is very angry as no once called the hospital today to chase the date. Please speak to the hospital and call her back*

Event Log – 17:51 – *Call hospital, they did not know the patient should be transfer to Gran Canarias. Explained to the nurse, pax is not fit to be repat, and pax should continue treatment in Gran Canarias. She will notify the doctor and we should call tomorrow to speak to the* [Dr O]*. She states there is a waiting list*

Event Log – 17:58 – *Call* [Ms D]*, explained according to the nurse there is a waiting list. She doesn't believe this is acceptable, explained we will contact the hospital tomorrow and speak to* [Dr O] *to get a better idea. Please call her, made her aware dr is between 8-2*

<u>27 February 2018</u>

12:31 – Email from Ms D to EAF:

Good afternoon, I have just received a really distressing call from my dad. The doctor has been to see him and told him he either needs to get back to the UK or he will have to make preparations for him to stay in Spain for the rest of his life and he will die there. I am absolutely appalled that the doctor would say something like that to my dad and I'm struggling to believe it. My dad has advised that's what he said word for word.

Whether that's what the doctor meant to say as there is a language barrier I am not sure, but it DIRECTLY CONTRADICTS what you are telling me and there was no discussion about going to Gran Canaria.

Can someone take responsibility for this and update me urgently…

Event Log – 13:23 – *CAll from* [Ms D] – *I advised* [Dr G] *will call her to dicuss the case at roughly 14:00*

14:49 – Email from Ms D to EAF:

> *…I have not received the call from the Doctor that was promised at 2pm.*
>
> *Please can you chase the doctor and get him to call me as you promised he would.*

28 February 2018

Event Log – 10:48 – *CAll to* [Ms D] – *she is not happy and wants a call from a manager – I said I will put the request in for her.* [Ms D] *would would like a call from the MT to discuss the case…*

Event Log – 11:09 – *Tried to CAll* [Dr G] *to discuss the case – number busy (3 times)*

Event Log – 11:31 – *CAll to* [Dr G] – *He is on holiday. He asked us to check with MJN*

Event Log – 11:46 – *CAll to* [Dr G] – *He is on holiday. He asked us to check with MJN – CAll to MJN to discuss the case. MJN agreed to look into the case.*

Event Log – 15:45 – *I* [case handler] *discussed with case with MJN who has spoke with pax daughter twice today and she is up to speed on the case management…*

Event Log – 15:53 – *call from British consulate stating that the hospital TD has stated that the pax has deteriorated and wants to kwow if they can have surgery private and that waiting list is 1 month in public and that only private have cardiology Dr who can treat pax immediately – advised that I would pass info to the case handler.*

Event Log – 16:32 – *Call with patients daughter* [Ms D] - *… Wants a copy of he policy wording and also for us to confirm if we will cover private treatment. She wants Dr Nadal to speak to the TD about her fathers care. Message passed to MJN.*

1 March 2018

09:23 – Email from Ms E to Ms D, later recorded in FCO [Foreign and Commonwealth Office] Log at 18:58:

> *'Dear* [Ms D]*,*
>
> *Please see the email below that I sent* [Ms DD] *earlier. I am forwarding this to you as she might already be travelling.*
>
> *I will answer your questions one by one for clarity:*
>
> [Question from Patient D's family] *Dr Nadal from Flexi cover has advised that the Lanzarote Equivalent of the NHS healthcare should cover the full cost of Dads treatment to include the medivac plane from Lanzarote to GCanaria under the EHIC card and that our government will fully reimburse the cost. He states Lanz. won't like to pay the cost for the medivac as when it's reimbursed the money goes back to Madrid not to them.*
>
> [Answer from Ms E] *The two Provisional Replacement Certificate's (PRCs) that have been issued by the DWP will cover the costs of all treatment at both public hospitals:*
> *• Hospital General de Lanzarote Dr. José Molina Orosa (where your father is at now in Lanzarote)*
> *• Hospital Universitario de Gran Canaria Dr. Negrín (where he will most likely be transferred to in Gran Canaria)*
> *The public healthcare system organises and covers the cost of the medivac (they usually transfer hospitalised patients from one island to another in a helicopter) and these costs will be reimbursed by the UK later on. It should not be the patient or the family's concern to worry about the disputes the local government has with the national government with regards to reimbursement of the costs.*
>
> [Question from Patient D's family] *Dr Nadal has promised to call you tomorrow* [Ms E]*. He has also promised to call the treating doctor in Lanzarote.so if you could provide his name and number perhaps a conference call could be set up tomorrow to discuss this together?*

[Answer from Ms E] *Please see my email below to* [Ms DD] *where I include the name and contact details for the cardiologist doctor who is treating your father.*

[Question from Ms DD] *Dr Nadal strongly advised against going Private as the standard of care can be far below that of the Spanish NHS as youbridk treatment from doctors whose credentials don't meet the standards off the Spanish NHS. Is there any credibility to this statement at all?*

[Answer from Ms E] *It is a fact that the Spanish public healthcare system and its hospitals do have more resources compared to private hospitals (specialists, latest technology, etc.), but to become a doctor in Spain, the credentials are the same for all professionals whether they work in a public or private entity.*

[Question from Patient D's family] *Dad will die If he doesn't get to the top of the waiting list anyway and as we dont know how long it will take to get to the top of the list we need to explore private care.*

[Answer from Ms E] [Dr O] *spoke to your sister* [Ms DD] *yesterday and told her that as soon as he received both PRCs (that I sent to the hospital yesterday by fax as requested by the doctor), he would process your father's application to be put on the waiting list to get the urgent treatment he needs in Gran Canaria. He said it could take up to a month for your father to be transferred as there are many patients needing urgent care as well and hospitals in the neighbour island are overwhelmed…*

[Question from Patient D's family] *Dr Nadal advised they will not fly him home on an air ambulance as it may well kill him as he has serious heart condition, loss of heart muscle, fluid on the lungs, his oxygen levels are only 85. He states the flight would increase heartwork, reduce oxygen levels further. Low pressure, low ozone & the acceleration force would seriously impact dad and cause more fluid on lungs.If oxygen levels deplete below 70 his organs will shut down and he could die. They wont accept liability for this in any way.*

[Answer from Ms E] *That is the insurance's decision and I cannot intervene. Yesterday I called to raise your concerns as a family and to provide information*

on local procedures if they needed clarification. The caseworker I spoke to made it clear that they are in contact with yourself and that they are taking correct measure to tackle situation.

[Question from Patient D's family] *He states dad's case has been discussed with a* [Dr G]*?*

[Answer from Ms E] *I am not aware of who* [Dr G] *is, sorry…*'

Event Log – 11:09 – *CAll from* [Ms D] – *She said she had had conversations with Miguel* [Dr Nadal] – *She has also spoke to TD whos opinion is different to Miguel,* [Ms D] *wants us to authorise private.*

Event Log – 11:11 – *I informed* [Ms D] *that private treatment should be approved by our MT before we approve.*

Event Log – 12:23 – *Completed Task – R Please call hospital and speak to the TD,* [Dr O]. *Please ask when pax possibly transfer to Dr. Negrin* [the public hospital in Gran Canaria] *for further treatment*

Event Log – 12:49 – [Entry from a Senior Manager at EAF] *Completed Task… I see that MJN is involved with this case but I see no logs from him. I feel he should continue to do so especially in the absence of* [Dr G]

Event Log – 12:49 – *Completed Task – R* - Please call* [Ms D] *and discuss the case she is very upset and has been told by the TD that PAX needs repat or he will die*

Event Log – 15:03 – [First entry in the Event Log from Dr Nadal] *MJN spoke to pax's daughter,* [Ms D], *yesterday. It became apparent that she was upset by our lack of effectiveness because staff gave her to understand that the Medical Team would expedite treatment and we have failed to do so. MJN explained that we have no influence on timing of surgery or the transfer to the Dr Negrin on Gran Canaria, this being a matter for the doctors on Lanzarote and at the Dr Negrin.* [Ms D] *then asked MJN to speak to* [Ms E], *a consular officer on Gran Canaria. M JN spoke to* [Ms E] *today. Much of the delay has been caused by pax having travelled to Lanzarote not in possession of an EHIC* [European Health Insurance Card]. *MJN asked if it is true that TD said pax would die within a month, and she said it was not. She quoted in Spanish*

what the TD said: pax might die at any time including during the treatment or as a result of the treatment, he did not say that pax would die within a month without treatment. Today, Thursday the 1st of March, MJN spoke to [Ms D] *again. She has a completely different attitude, demanding authorisation for private treatment on Lanzarote or private treatment elsewhere in the Canary Islands. She argues that this was our fault that the absence of an EHIC and the failure to obtain a PRC* [Provisional Replacement Certificate which can be issued where an EHIC card is not available] *sooner; MJN explained that PRCs within the Single Market are obtained by the service provider who is supposed to communicate directly with the Dept. of Work and Pensions. She asked for private treatment, so MJN said that was an insurance matter but, whatever was decided, we never allow any of our clients to obtain treatment at any Hospiten facilities because we have grave reservations about their clinical and commercial practices.* [Ms D] *accused MJN or lying, or of* [Ms E] *having lied. MJN objected this allegation and* explained why. [Ms D] *demanded all records and our reasoning in writing to her, but MJN said he would not complete because he has no authority to do so.* [Ms D] *says she will go to the media. The conversation ended by* [Ms D] *hanging up.*

Event Log – 17:51 – [Entry from a Senior Manager at EAF] – *Long conversation with* [Ms D] *ith regards the complaint made.* [Ms D] *explained the whole wituation with regards to the conversation he had with MJN and with regards the actin that the EAF team was taking. I explained that I would investigate all of this and that from now my priority would be to help* [Patient D]. *I explained that now what we have to do is make suer that we have a full understand on when* [Patient D] *will have teh operation. The Plan is for us to contact the hospital, have an understand of the waiting list and get as much information as possible then tomorrow I will call her back and discuss what would be the best action to take*

Event Log – 17:53 – [Entry from a Senior Manager at EAF] – *Completed Task – URGENT CHS PAX TRANSFER to Grana Canaria As we discuss , please chase if possible today the on call team and inform our recommendation regarding completing investigations and treatment under EHC agreement before repat to UK , many thanks*

Event Log – 18:05 – *Called hospital and they have request to call the hospital tomorrow after 8am to speak with the TD.*

2 March 2018

Event Log – 08:28 – [Call handler] *Called the hospital and tried to speak to TD* [Dr O]*, which was not available and there is not doctor available to speak atm they have asked to call later on this morning.*

Event Log – 09:28 – [Call handler] *Called hospital to speak with TD* [Dr O] *regarding pax case. How long is the patient on a waiting list for waiting for his surgery? An updated medical report on the patients condition is this patient going to die if he waits for the surgery? Receiving treatment via EHIC?*

Event Log – 09:29 – *Called the hospital and* [Dr O] *is not available mentioned nurse* [Nurse S] *to call later*

Event Log – 09:33 – *Called the hospital at 09:29 spoken to the* [Nurse S] *and request to call later to speak with TD.* [Nurse S] *has mentioned though that they have request catheterism for pax but the waiting list is 1 month and pax cannot be transfer to another hospital (public) but can be done privately. I have request more information but he has request to contact TD later.*

Event Log – 11:00 – [Call handler] *Called Oncology to speak with TD* [Dr O]*. TD is on surgery atm and is not available to speak on oncology ward he has mentioned to call* [redacted] *to request the telephonist to trace TD in the hospital, call the telephonist and she has mentioned will transfer the call TD* [Dr O]*. Spoken to the TD and he has mentioned that the hospital hasnt got the monitor/facilities to operate pax he has also mentioned that he is receiving the same treatment as the Spanish people and the waiting list is for 1 month for Spanish ad British mentioned if there is a possibility of pax die he has mentioned that pax has got some complications and mentioned what is the possibility of pax die on AA he has mentioned will send the MR to us with the information and has tried 7 times and fail, he has mentioned that here in the UK we have the facilities to deal with pax and Spain for to be a small island they dont have I have mentioned for pax to be transfer to another hospital he has said he does not know but need to be air lifeted to another hospital with the facilities to do the operation, he will send the MR to us*

Event Log – 11:03 – *Completed Task – R – Please call the hospital and ask for a medical report…*

5 March 2018

Event Log – 10:26 – *Completed Task – R – please CHS* [chase] *MR urgently*

Event Log – 12:16 – *Document Uploaded: …mr.pdf*

Event Log – 12:23 – *Made MJN aware of the new mr attached to case*

Event Log – 12:30 – [Entry by Dr Nadal] *MJN has spoken to the nurse in charge of the ward,* [Nurse S]. *The treating doctor,* [Dr O]*, was in out-patients and a colleague was doing the rounds on the ward;* [Dr O] *unlikely to return to the ward today.* [Nurse S] *said the patient was placed on the waiting list last week on account of the delays concerning the EHIC/PRC, and he will be sent to the Doctor Negrín hospital when he reaches the top of the waiting list. He confirmed that the position on the waiting list depends on two things: the time on the list as well as the gravity of the patient's condition. The average wait is about one month. He confirmed that patients less ill than* [Patient D] *are sent home to wait for the intervention, however* [Patient D] *is not well enough to leave hospital.*

Event Log – 15:54 – [Entry from a Senior Manager at EAF] – *Managed to speak to* [Ms D]*… I have the chance to explain that we managed to speak to a member of the medical team at the hospital and confirmed to her that now the EHIC is sorted. I also explained that the plan from the hospital is to move dad to teh Dottor Negrin hospital when he would be able to be moved. I have told her that tomorrow we will call back the TD to discuss teh specific medical condition and then I will call herback*

Event Log – 21:45 – *Document Uploaded: MR* [Patient D]

Event Log – 22:19 – *Document Uploaded: MR 3* [Patient D]

> [Medical report, dated 2 March 2028 stated]:
>
> *Plan*
> *Report is being sent to his insurance company to arrange patient's repatriation as per the family's wishes and the insurance company's request.*

Patient requires air ambulance transport and transfer to a centre with capability to perform a primary angioplasty.

6 March 2018

Event Log – 09:29 – *Email sent to MJN to review the MR and refer to* [Senior EAF Employee] *ASAP.* [Senior EAF Manager] *will need to update pax's daughter*

Event Log – 14:46 – [Entry from a Senior Manager at EAF] – *Managed to speak to* [Ms D] *that she was in a bad state.* [Ms D] *told me that her father is not improving and that is gettong warst. Dhe explained that the Doctors at the hospital mentioned to her that all his Organs are failing and that they advised to move him back home at the operation it can take 30 to 40 days.* [Ms D] *was crying while she was on the phone with me and she explained that at this point she would like for her father to flight back home with an AA. I have explained that we don't know if it would be safe to do so.* [Ms D] *told me that at this point she would like to risk.* [Ms D] *stated that the patient told her that he wants to come home.* [Ms D] *is extremely concern about the fact that if her father is going to die, she will held TIF responsible of it. According with her the doctors are telling her that a week ago was the best time to move her father back to the UK and all was ok by now. I explained that this is not easy to say however I confirmed that we are trying to contact the hospital as the MR that we received is not great. I have explained that our mission is to help the patient but again* [Ms D] *asked that we do something and that we start to consider an AA repat even if here is a risk.* [Ms D] *asked for her father not to day in Spain. I have ended the call to confirm to* [Ms D] *that we will call the hospital and try to speak to a TD to see the situation then I will get back to her*

Event Log – 15:50 – [Entry from Senior EAF Employee] – *daily call with* [Ms D]. [Ms D] *was very emotional and worried about her dad, she mentioned that the TD mentioned to her that the operation will take 30 to 40 days and that her dad organs are failing. she mentioned that at the moment is depressed due to the all situation and she asked for us to help and do something. I have explained that the reason for my call was due to give her an update and to confirm that we received a MR. I have explained that the MR is generic and that the information we have did not mention organ failure or depression. however one of our doctors was on the case to call the hospital and speak to the TD. I have explained that we tried to speak to the TD this morning (*[Dr O]*) but with no luck as the doctor is off duty today (*[Ms D] *confirmed it) and I reassured her*

that we are still trying to call the hospital as we were advised to speak to [Dr T]. [Ms D] *also aware of this as she confirmed that the information that gave me were from* [Dr T]. [Ms D] *also confirmed that Doctor Borgne stated pox is FTF* [Fit to Fly] *with an AA and that we should consider to repat the patient ASAP. I tried to explain to* [Ms D] *that out mission will be to put pressing to the hospital to reduce the waiting list time and to understand why if so urgent the operation still did not happen. With regards the AA I have explained to* [Ms D] *that at the present we are not able to comment as it might be dangerous to AA pax back to UK due to the medical condition has he might die.* [Ms D] *understood that but she said that at this point she would like to risk it.* [Ms D] *stated that her father asked to go back home ASAP.* [Ms D] *also stated that if her dad is going to die in Spain she will take legal action against us and the hospital. I ended the conversation explaining that at the moment we need to speak to the TD ASAP and confirm and have a better understand of what stated to her and on the MR. I reassure her that we will help as match as we can and that I will personally be there to help. The plan is for MJN to call the hospital and update me with regard the above comments.*

Event Log – 15:50 – [Entry from Dr Nadal] – *MJN has spoken to*[Dr T]*, the cardiologist on duty today. The essential facts are that the patient is unwell, he satisfies the criteria for urgent though not immediate coronary angiography, and his left ventricular ejection fraction is 30%. If and when the coronary intervention is carried out successfully, little improvement is to be expected, but it might slow down his deterioration. From the cardiac point of view, the patient's condition is not critical, but is poor and stable; if it becomes 'critical', he will be transferred to the Dr Negrin Hospital as an emergency…*[Dr T] *added that the family are unhappy because the patient is in possession of an insurance policy and they would prefer the insurer repatriate him as other companies and countries do. MJN explained that it would be wrongful to repatriate* [Patient D] *and, if he were to die or suffer harm as a consequence of the flight, the insurer could be found to have been negligent and the EAF doctors recommending the air-ambulance home, in the present circumstances, could, in the light of recent legal developments, find themselves being charged with manslaughter. Finally, MJN asked how long he thought* [Patient D] *might have to wait to be transferred to the Dr Negrin.* [Dr T] *replied that it might be one or two weeks more. Finally, it ought to be noted that the waiting times for the cardiac interventions are significantly less in Spain than in England: this applies to all other Mediterranean countries that are members of the Single Market. MJN recommends that if the family want to insist on an air-ambulance transfer, they should be provided with the contact*

numbers for Capital, FAI and JetCall, with the suggestion that they inform the companies that EAF refused to arrange the transfer on medical grounds; this will ensure they are not grossly overcharged. If they wat to follow up this option, the family ought to be told that the limit of insurer liability will be the cost of the entire assistance would have cost had EAF managed the case until his return or repatriation to the UK.

7 March 2018

Event Log – 13:09 – *Call led by* [Senior Manager at EAF] *to* [Ms D]*… he explained that we had been advised by* [Dr T] *that the waiting time had now shortened to 1-2 weeks, that her Dad was currently stable.* [Senior EAF Employee] *reiterated that EAF Medical team had spoken with* [Dr T] *and whilst stable, we EAF MT did not consider her dad to be f2f, by AA, due to the high risk, it would be safer for him to have surgery locally and review repatriation post surgery.* [Ms D] *asked if this would be by AA.* [Senior EAF Employee] *replied if that's what was necessary at the time, then yes.* [Ms D] *asked what the surgery was – Angiogram* [Ms D] *accepted this,* [Senior EAF Employee] *advised that even if they wanted to arrange their own AA, we/he would still advised that it was not a safe thing to do in the current situation, however if they did it, we would offer a contribution to the costs.* [Ms D] *accepted this and was happier with the reduced waiting time, she reiterated that she wants the best for her Dad and wants him home safe…*

14 March 2018

Event Log – 11:16 – [Entry from a Senior Manager at EAF] – *Phone call with* [Ms D] *to check if all ok and to return her call as requested via email.* [Ms D] *was in tears as she wad advised by the hospital that her dad gone down the list, according with* [Ms D] *he was on number 8 and that now they moved him to number 11.* [Ms D]*'s dad* (pax) *requested to return home as its too much for him now. I have explained to* [Ms D] *that this morning we tried to chased a new MR and that at the moment we are waiting for it.* [Ms D] *was begging for help. I told her that we will try to get in touch with the hospital to have a better understand and then update her.*

15 March 2018

Event Log – 10:20 – [Entry from a Senior Manager at EAF] – *Phone call to* [Ms D] *related to the last email sent to us. I have explained that I will send the email with the providers that we use. I suggested to her to contact all of theme and get a quote… I confirmed to her that it would be better for her father to stay there however this would be her decision.* [Ms D] *mentioned that* [Ms DD] *would like to return to the UK and that she would like to go out. I agreed that we will pay for it*

Event Log – 10:35 – *Completed Task – R – New MR on file*

> [Medical report, dated 14 March 2018 stated]:
>
> *PLAN:*
> *UPDATED REPORT IS BEING SENT AT THE REQUEST OF THE MEDICAL INSURANCE COMPANY FOR HIS REPATRIATION BY AIR AMBULANCE.*

21 March 2018

10:54 – Email from Ms D to EAF:

> *…We have booked an air ambulance for this Friday… We can't get one earlier due to beds in the UK but the Dr here confirmed* [Patient D] *is not going to* [Gran Canaria] *anytime soon so* [Patient D] *felt he would rather take his chances getting home which is very worrying but it's his wishes…*

Event Log – 11:09 – [Entry from a Senior Manager at EAF] – *Email sent to* [Ms D] *pax's daughter to check if she is definitely planning to go ahead with their won plan to repat pax via AA against our medical advise*

26 March 2018

Event Log – 14:49 – [Entry from a Senior Manager at EAF] – *Call with* [Ms D] *to check if they arrived safe in the UK.* [Ms D] *confirmed that* [Patient D] *in the UK and at the hospital, she mentioned that, the UK doctors mentioned that pax while in Spain had a stroke and that no oen noticed it. Due to this the reckon that he will die soon…*

28 March 2018

06:58 – [Ms D emailed EAF to confirm that Patient D had passed away.]

Dr Nadal's case in respect of Patient D

193. Dr Nadal's consistent evidence was that Spain had high quality public hospitals with very good medical provision. Dr Nadal, whose first language is Spanish, had a good deal of experience and specific knowledge of Spanish healthcare, particularly in relation to cardiac facilities. The Tribunal was told that Dr G worked half of each year in Spain and had direct experience of working at hospitals in the Canary Islands and so was extremely familiar with the facilities and processes. The GMC did not challenge Dr Nadal's evidence in this regard and the Tribunal accepted this evidence.

194. Dr Nadal and Dr G knew that, at the time of events, the United Kingdom was a member of the European Union (EU) and as such Patient D was entitled to, and should have been able to, access medical treatment under the EHIC regime. For this reason, Dr Nadal considered that air repatriation was contraindicated. Moreover, his assessment of Patient D, from what he had learned from the medical reports was that Patient D would be best served by remaining where he was, in Lanzarote. Dr Nadal and Dr G considered that Patient D was not sufficiently well to be transported and so the risks were too great for an air ambulance repatriation to the UK. They both considered that Patient D's best interests lay in a much shorter, and less risky, air ambulance transfer to Gran Canaria where he could receive the treatment he needed. Thereafter, when Patient D was sufficiently well, he would be repatriated.

195. Dr Nadal's position was that, to his knowledge, there were a number of doctors who were involved in Patient D's care at the hospital in Lanzarote. It was only one of these doctors, Dr O, who had apparently advised that Patient D should be repatriated to the UK. It was Dr Nadal's case that he knew from previous experience that Dr O was someone who routinely recommended repatriation to the UK in cardiac cases despite the availability and accessibility of a well-developed healthcare system in Spain and its territories. Dr Nadal believed that although this was not in the best interests of patients, Dr O would suggest repatriation in order to relieve pressure on the Spanish healthcare system. Similarly, Dr Nadal stated that it was his experience that Dr O would always say it would be 'a month' until a patient received (cardiac) treatment. Dr Nadal's evidence was that it was his experience that

such treatment would usually be received much sooner, and usually no more than two weeks.

196. Dr Nadal's view was that due to Patient D's comorbidities and significant heart condition, the best and speediest treatment would be within the Spanish public healthcare system under the EHIC regime. He considered that it was safest for Patient D to remain and be transferred from Lanzarote (where angiography facilities were not available) by air ambulance to the Dr Negrin public hospital on Gran Canaria, as was the routine procedure for all local Spanish patients.

197. The Tribunal observed that Patient D's case presented a significantly different scenario to that of Patient B because Dr Nadal did have significant experience and knowledge of handling cases similar to Patient D; particularly patients who had suffered a cardiac event; the cardiac facilities in Spain and its territories; and the Spanish processes generally. It was Dr Nadal's evidence, which was not challenged by the GMC, that over the years he had been involved in very many cardiac cases in this region. The Tribunal accepted that both Dr Nadal and Dr G had considerable knowledge of the available cardiac facilities in Spain and could properly rely on their knowledge and past experience. At the relevant time, the UK was a full member of the EU and Dr Nadal held the reasonable belief, based on his extensive knowledge of the Spanish healthcare system, that Patient D would have been entitled to expect that treatment would be available to him in Spain as if Patient D was a Spanish citizen.

Paragraph 5

198. In respect of Patient D, the Tribunal was first required to consider whether between 28 February and 4 March 2018, Dr Nadal's care of Patient D was inadequate in that he failed to make any direct contact with the treating clinician to monitor Patient D's clinical condition and progress.

199. Dr Nadal accepted as a fact that he did not contact Patient D's treating clinician between 28 February and 4 March 2018. It was Dr Nadal's case that this was not a failing on his part because he had all of the information he needed to have an appreciation of Patient D's medical condition and the care that he was receiving at that time.

200. The Tribunal had regard to Dr Q's report, dated 9 December 2019. It considered, as had been submitted by Mr Geering on behalf of Dr Nadal, that there was an apparent contradiction in Dr Q's evidence in that Dr Q stated in his report:

'6.6 (a) Communication with hospitals in foreign countries is often difficult. Issues include time differences, medical staff shift patterns and language problems. In my opinion, however, ***the information EAF were receiving/obtaining from the hospital in Arrecife pertaining to*** [Patient D]***'s condition was sufficient to have a reasonable on-going understanding of his illness.*** *In my opinion, however, there was a lack of direct contact between the medical team at EAF (of which Dr Nadal was the Director) and treating clinicians.*
[The Tribunal's emphasis]

6.6 The call records indicate that the first contact by a member of medical staff [Dr G] *with a local treating clinician was not until 23rd February (see paragraph 5.5 above).* [Dr G] *subsequently went on holiday and on 28th February Dr Nadal took over the case. Dr Nadal did not, however, attempt to speak to a treating doctor until 5th March, despite messages and telephone conversations with* [Patient D]*'s daughter during which continuing concern for her father's survival was clearly expressed. Unfortunately, Dr Nadal was unable to speak to a treating clinician on 5th March and telephoned back the following day (pages 112 and subsequent pages). On 6th March Dr Nadal had a conversation with the treating cardiologist during which the details of* [Patient D]*'s condition and status were discussed. In my opinion this conversation should have taken place several weeks earlier. Although Dr Nadal was not initially handling the case, as medical director he must bear some responsibility for the delay in initial medical contact.* ***Having taken over direct responsibility on 28th February, I consider Dr Nadal's personal decision not to contact medical staff before 5th March represents care below an expected standard****, particularly in light of* [Patient D]*'s daughter being told 4 days previously her father would die unless repatriated…*
[The Tribunal's emphasis]

201. However, when considering the specific question as to whether Dr Nadal had ensured he had sufficient information about the facility and the resources available at the hospital and Patient D's clinical condition when making his decision on the risks versus benefits of aeromedical repatriation, Dr Q stated:

6.9 In my opinion, ***despite the delay in contacting the treating clinician directly (see paragraph 6.6 above), from the medical report and other communications Dr Nadal had sufficient information to make an informed and educated decision about the risks and potential benefits of repatriation****…'*
[The Tribunal's emphasis]

202. The Tribunal also had regard to the fact that Dr Nadal had access to the following information from the medical reports and EAF communications with the hospital:

12 February 2018

15:34 – *Document Uploaded: MR* – [Patient D].*pdf*

[Medical report, dated 12 February 2018, indicated that Patient D had been admitted to Hospital Dr José Molina Orosa Arricefe with a heart attack. Under the heading *'Clinical Judgement'*, it said]:

- ACUTE CORONARY SYNDROME WITH ST-SEGMENT ELEVATION IN PATIENT WITH PROBABLE CHRONIC CARDIOPATHY. KILLIP III. TIMI 5 (HIGH RISK). GRACE 188 (HIGH RISK). CRUSADE 48 (HIGH RISK).
- PROBABLE RESPIRATORY TRACT INFECTION AS TRIGGER
- FIRST DEGREE AV BLOCK

13 February 2018

00:26 –*…Pax admitted for STEMI (probably chronic cardiac disease) high risk chest infection Pax on oxygen… the patient will need possible transfer to main island (Gran Canaria) for cath lab . awaiting medical updates*

00:30 – *Completed Task – R – pls MR on file in Spanish – hospital are saying to repat via AA or stay for 3 months*

20 February 2018

15:02 – *Called the hospital and spoke with Oncology ward with the TD* [Treating Doctor] [Dr O]*, pax need an ambulance to transfer to the UK pax needs operation*

catheterism and need to wait 1 month for the operation TD mentioned that pax need to come home to have the operation in the UK TD will send the MR to us

16:27 – *CAll to hospital to chase MR – I was put through to the oncology department. PAX is progressing – PAX has a lung infection and has had an MI* [Myocardial Infarct]. *PAX has 40% Dysfunction of the heart. The hospital will fax us a MR to ops tomorrow morning urgently. The hospital thinks PAX may need an AA.*

23 February 2018

17:12 – [Entry from Dr G] *Progress changed from None to Update MR ; ETT ; severe global ventricular dysfunction akinetic lateral inferior and posterior wall . Complete the atb due to chest infection . TD suggested AA for cath lab.in UK Assessed case with MJN we both agreed that TD should complete the investigation and treatment under EHC agreement and then repat (when patient is safe) if the hospital do not have the facilities they need to transfer the to the main island (Gran Canaria) . Called daughter and explain the same reasons why we do not contemplate to repat on AA due to high risk . Called several times to hospital on call team availability only – they have a emergency unable to attend. Discussed case with [case handler] she will try to contact on call team and discuss our position , also the daughter will like to be updated .*

17:12 – *Completed Task – Full DMR now on file*

203. The Tribunal accepted Dr Q's opinion, as expressed at 6.9 of his report, that Dr Nadal had sufficient material between 28 February and 4 March 2018 to inform his decision-making. Therefore, there was no necessity for Dr Nadal to contact Patient D's treating clinician in order to monitor Patient D's clinical condition and progress during this period. Furthermore, it was clear from the event log that numerous attempts had been made by EAF staff to contact treating clinicians at the hospital, particularly when it became clear that one of the medical reports was incomplete. The Tribunal reminded itself that whilst a report was produced on 2 March 2018, it was not available for review by Dr Nadal and the medical team until 5 March 2018.

204. The Tribunal had particular regard to the discussion recorded as having occurred between Dr G and Dr Nadal on 23 February 2018. It was clear from the events log that a reasoned discussion about Patient D's case had been undertaken and that from that point on

EAF were consistent in their view about how to best meet the needs of Patient D. This was communicated to the hospital on the same day.

205. Accordingly, the Tribunal determined that, in the particular circumstances of Patient D's case, and based on the information that was available to Dr Nadal when considering his care, there was no requirement on Dr Nadal to make direct contact with Patient D's treating clinician between 28 February and 4 March 2018.

206. The Tribunal found paragraph 5 of the Allegation not proved.

Paragraph 6.a

207. The Tribunal was required to determine whether, from 21 February 2018 onwards, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to have sufficient regard to four alleged facts (i. to iv.) relating to Patient D's condition.

208. In considering this paragraph of the Allegation, the Tribunal accepted that Dr Nadal did not take over responsibility for Patient D's case until 28 February 2018. Prior to 28 February 2018, Dr G was the member of the medical team responsible for Patient D's case, although Dr G had consulted with Dr Nadal on 23 February 2018 when they, based upon the available medical evidence, had formed the joint view that it was not safe to repatriate Patient D at that time.

209. From 23 February 2018 onwards Dr Nadal maintained his view that repatriation was not in the best interest of Patient D. In these circumstances, the Tribunal was required to determine whether the decision made on 23 February 2018 was inadequate, and continued to be inadequate, from 23 February 2018 onwards.

210. The Tribunal considered paragraphs 6.a.i and 6.a.ii of the Allegation together. The Tribunal was required to determine whether, during the relevant period identified, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to have sufficient regard to the facts that Patient D had suffered a major cardiac event against the background of chronic cardiac disease and had a life-threatening condition.

211. On 23 February 2018, Dr G assessed Patient D's case with Dr Nadal. As a result of their discussion, both agreed that having had sight of two medical reports which provided significant detail about Patient D's condition and his comorbidities, it was in Patient D's best

interests for investigations and treatment to be completed locally, in the Canary Islands, and then to repatriate Patient D back to the UK after treatment and when it was safe (for Patient D) to do so. Dr Nadal and Dr G concluded that to repatriate Patient D by air ambulance to the UK at that time would have been too high a risk for Patient D. Dr G communicated this decision not to repatriate Patient D to Ms D on the same day.

212. The Tribunal considered that Dr Nadal, with Dr G, had made a reasoned joint decision on 23 February 2018, at a time when they had sufficient information as to Patient D's medical condition and they gave clear and adequate consideration to the fact that Patient D had suffered a major cardiac event against the background of chronic cardiac disease and that it was a life-threatening condition.

213. In the Tribunal's judgment, and having regard to the decision made by Dr Nadal and Dr G on 23 February 2018, there was no material change in Patient D's medical condition, he had still suffered a major cardiac event against the background of chronic cardiac disease and it continued to be a life-threatening condition.

214. The Tribunal had regard to the fact that Dr Q's opinion was that *'In my opinion, faced with this information and the strong desire of the daughters for their father to be repatriated, the balance of risks was strongly in favour of repatriation by air to the UK.'* However, the Tribunal reminded itself that in his oral evidence Dr Q had accepted that the balance of risks always required a judgement call and he accepted that some people might (reasonably) disagree with him. He said *'I would have no problem with them disagreeing with me had they sought the necessary information on which to make that decision'*.

215. For the reasons already set out, the Tribunal was satisfied that Dr Nadal did have the necessary information to make a decision about the potential repatriation of Patient D to the UK.

216. The Tribunal concluded that Dr Nadal had continued to have regard to the facts that Patient D had suffered a major cardiac event against the background of chronic cardiac disease and that his condition remained life-threatening. Indeed, it was Dr Nadal's regard to these facts, and others, that led him to form the judgement that Patient D should not be repatriated to the UK for treatment because it was unsafe to do so. Having made such a decision, on a reasoned basis, there was no need to re-consider this decision as the facts had not changed.

217. The Tribunal found paragraph 6.a.i and 6.a.ii of the Allegation not proved.

6.a.iii

218. The Tribunal was required to determine whether, during the relevant period identified, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to have sufficient regard to the fact that Patient D did not initially have a rapidly deteriorating condition.

219. The Tribunal had regard to the basis on which this paragraph of the Allegation was put by the GMC. Dr Q's evidence was that Dr Nadal knew that Patient D *'had a life-threatening condition but that, at least initially, his condition was not obviously rapidly deteriorating such that there was a clear potential window of opportunity for early repatriation.'*

220. The Tribunal accepted Mr Geering's submissions that the *'initial'* period of time for the consideration of repatriation was when Patient D had recently been admitted to hospital. Patient D was admitted on 11 February 2018. Dr Nadal was first made aware of the case when Dr G discussed it with him on 23 February 2018. This was 12 days after Patient D had been admitted following a heart attack. Patient D's condition had significantly declined between those dates. Dr Q confirmed the extent of Patient D's deterioration in his oral evidence and referred to a concerning echocardiogram that had been undertaken on 23 February 2018. The Tribunal accepted, if there had been a period of stability that could have made for a safer repatriation to the UK for Patient D, this period had already passed by the time Dr Nadal had any responsibility for the case, i.e. 23 February 2018. Up until this time, it had been Dr G, who had been the member of the medical team dealing with Patient D's case.

221. The Tribunal found that Dr Nadal could not have been responsible for any decision made before he was aware of, or responsible for, Patient D's case.

222. Furthermore, in the Tribunal's judgment, Dr Nadal had reached a reasonable conclusion about how best Patient D's needs could be met. He had concluded, at that time, that Patient D's best interests would be served by remaining in Spain for treatment. The Tribunal considered that Dr Nadal had sufficient information as to Patient D's medical condition at this time to reach this conclusion.

223. The Tribunal found paragraph 6.a.iii of the Allegation not proved.

6.a.iv

224. The Tribunal was required to determine whether, during the relevant period identified, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to have sufficient regard to the fact that Patient D would likely need to wait at least a month for cardiac catheterisation locally.

225. The Tribunal acknowledged that it was clear from the event log that both Patient D's family members and representatives from the hospital had reported that Patient D would be waiting at least a month for cardiac catheterisation.

226. At the time Dr Nadal had doubted the accuracy of this time estimate because it was not in accordance with his knowledge and experience of waiting times for the same or similar procedures in Spain and its territories. It was Dr Nadal's evidence that Dr O, whom he had previously dealt with on numerous occasions in relation to cardiac cases, would always say the waiting time for treatment would be a month irrespective of the circumstances. This evidence was not challenged on behalf of the GMC.

227. Furthermore, the Tribunal had regard to the event log entry from 6 March 2018 at 15:50:

> *'15:50* – [Entry from Dr Nadal] – *MJN has spoken to* [Dr T]*, the cardiologist on duty today. The essential facts are that the patient is unwell, he satisfies the criteria for urgent though not immediate coronary angiography, and his left ventricular ejection fraction is 30%. If and when the coronary intervention is carried out successfully, little improvement is to be expected, but it might slow down his deterioration. From the cardiac point of view, the patient's condition is not critical, but is poor and stable; if it becomes 'critical', he will be transferred to the Dr Negrin Hospital as an emergency… Finally, MJN asked how long he thought* [Patient D] *might have to wait to be transferred to the Dr Negrin.* [Dr T] *replied that it might be one or two weeks more…'*

228. The Tribunal also had the benefit of the translated transcript of this call between Dr Nadal and Dr T, another of the treating cardiologists at the hospital. During the course of the conversation with Dr Nadal, Dr T confirmed that Patient D was in a stable condition and that catheterisation had been requested but that there was a wait. Dr Nadal asked what the protocol was, how long would Patient D wait and what risk Patient D was at. Dr T replied *'We*

have a waiting list this depend of the hospital, we have protocol if is urgent we deal'. Dr T said that Patient D would have to wait one or two weeks like other (Spanish) patients.

229. By the time of this conversation, on 6 March, Patient D had been in hospital for approximately three and a half weeks. However, it appears that the reason why Patient D had not received treatment earlier was because Patient D had been unable to produce an EHIC card at the time that he was first admitted to hospital. As a result, it had been necessary for Patient D's family, with the assistance of a British Consular Officer in Spain, Ms E, to obtain a Provisional Replacement Card (PRC) and which was obtained on or about 1 March 2018. The Tribunal accepted that Dr Nadal had not been aware of any difficulty with regard to the EHIC card until he spoke to Ms E on 1 March by which time this issue had been resolved.

230. Despite the indications apparent from the event log that Patient D was said, at various times, likely to have to wait a month for treatment, the Tribunal accepted Dr Nadal's evidence that he had reasonable grounds to expect that in fact Patient D would not have to wait over a month for treatment.

231. The Tribunal acknowledged that the waiting list for transfer to the Dr Negrin hospital would have been dynamic depending on the level of urgency and how long a patient had already been waiting. The Tribunal considered that this was not any different from how waiting lists operate in the UK. Having considered Dr T's conversation with Dr Nadal, the Tribunal concluded that the overriding principle relevant to Patient D's treatment was that if Patient D's case became more urgent, he would be treated appropriately and transferred.

232. The Tribunal concluded, that notwithstanding that a waiting time of one month had been suggested (the Tribunal noted that this was not stated in any of the medical reports from the hospital), Dr Nadal's knowledge and prior experience was that the waiting time could be expected to be less than this. Furthermore, Dr T had told Dr Nadal, on 6 March, that if Patient D's condition became urgent and required treatment sooner, he would receive it. For the reasons given in relation to paragraphs 6.a.i-iii, the Tribunal accepted Dr Nadal's judgement was reasonable in the circumstances even if Patient D would have had to wait up to a month before treatment, particularly bearing in mind that Dr Nadal had (reasonably) concluded that the risks to Patient D of air ambulance repatriation back to the UK outweighed the risks of remaining for treatment locally in Spain. The fact that Patient D might have to wait at least a month in Lanzarote would not have outweighed the risks already identified by Dr Nadal.

233. The Tribunal found paragraph 6.a.iv of the Allegation not proved.

Paragraph 6.b.i

234. The Tribunal was required to determine whether, during the relevant period identified, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to have regard to the treating clinicians view that Patient D required urgent catheterisation with or without treatment.

235. As previously stated, the Tribunal considered that Dr Nadal did not have any responsibility for Patient D's case until 23 February 2018 following his discussion with Dr G.

236. The Tribunal considered that by 23 February 2018, on the information then available, Patient D undoubtedly was in need of catheterisation and that without it, the prognosis was poor. To this extent, as Dr Nadal appeared to accept, the sooner Patient D had this procedure the better. However, the Tribunal determined that what might be described as 'urgent' in this context must necessarily be a matter of fact and degree because any patient with a life-threatening cardiac condition which would not improve without treatment might be regarded as 'urgent'.

237. In these circumstances, the Tribunal considered that the question that Dr Nadal needed to consider, from 23 February 2018 onwards, was not whether Patient D required 'urgent' catheterisation but whether, all other factors being equal, Patient D would get the catheterisation sooner in Spain or the UK.

238. In this respect, the Tribunal had regard to Dr Nadal's conversation with Dr T on 6 March 2018. Dr T confirmed that Patient D's condition was stable and, because of this, the wait for treatment was what he said was the standard one of one or two weeks. Although he added that, if Patient D's condition became 'urgent', he would be dealt with sooner.

239. Accordingly, the Tribunal determined that, whilst Patient D undoubtedly required urgent catheterisation, Dr Nadal was entitled to conclude on the information available to him on 23 February 2018 and thereafter that Patient D was unlikely to receive this treatment any sooner if repatriated to the UK. Furthermore, he was entitled on the information available to him, to conclude that, in any event, the risk to Patient D of repatriation by air ambulance to the UK outweighed the risks of awaiting treatment locally.

240. The Tribunal found paragraph 6.b.i of the Allegation not proved.

Paragraph 6.b.ii

241. The Tribunal was required to determine whether, during the relevant period identified, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to have regard to the treating clinicians view that Patient D would die without cardiac catheterisation, related to Dr Nadal by Ms E, the Consulate Representative.

242. In relation to this paragraph of the Allegation, the GMC relied upon entries contained within an FCO log, in which communications between Ms E and respectively, Ms D and Dr Nadal, were recorded. Ms E was not called as a witness on behalf of the GMC and there was no transcript of the conversation between Ms E and Dr Nadal during which it was alleged that it was reported to him that Patient D would die without cardiac catheterisation.

243. The specific FCO record upon which the GMC relied was a note of a conversation on 1 March 2018, between Ms E and Ms D. It was recorded in this note that Ms E had clarified what she had spoken to Dr Nadal about in an earlier conversation with him. Ms E recorded that she had told Dr Nadal that Dr O had said that *'the waiting list for* [Patient D] *to be transferred to Gran Canaria would now be approx. 1 month. The Dr. that day had doubts whether* [Patient D] *would be able to wait so long and feared he would pass away'*.

244. The Tribunal accepted that if this was an accurate record of the conversation Ms E had had with Dr O, which had been relayed to Dr Nadal, then it would be implicit that Dr Nadal had been informed that the treating clinician's view was that Patient D 'would die without cardiac catheterisation' as alleged.

245. However, the Tribunal considered that the evidence of what Ms E had relayed to Dr Nadal regarding Dr O's view was highly unsatisfactory in that it relied on hearsay upon hearsay relaying the content of the conversation in English when the original conversation had been conducted, the Tribunal understood, in Spanish. The Tribunal considered that the evidence was such that there was a significant risk of misinterpretation of that which was actually said by Dr O and/or the context of what had been said by him.

246. Dr Nadal's evidence in relation to his conversation with Ms E was that she had told him that Dr O had said words to the effect that Patient D *'might die at any time including*

during the treatment or as a result of the treatment' and that he had not been told that Dr O had said that Patient D would die within a month without treatment.

247. The Tribunal noted that Dr Nadal's recollection of his conversation with Ms E was entirely consistent with the entry Dr Nadal made in the EAF event log at 15:03 on 1 March 2018:

> *'…M JN spoke to* [Ms E] *today. Much of the delay has been caused by pax having travelled to Lanzarote not in possession of an EHIC. MJN asked if it is true that TD said pax would die within a month, and she said it was not. She quoted in Spanish what the TD said: pax might die at any time including during the treatment or as a result of the treatment, he did not say that pax would die within a month without treatment.'*

248. Furthermore, the Tribunal had a transcript of a conversation that Dr Nadal had with Ms D in the afternoon of 1 March 2018. During this conversation, Ms D challenged Dr Nadal on what Ms E had told her Dr O had said, namely Patient D *'would die within the month'*. Dr Nadal's response was that he had spoken to Ms E and that she, Ms E, had denied that Dr O had said this and he stated that Ms E had quoted Dr O as saying *'he could die this week, today, tomorrow, this week…a month or much later or during treatment'*.

249. The Tribunal considered that this transcript of a call that was near contemporaneous with the events, was likely to be more accurate than the Ms E's summary contained in the FCO record of what Ms E had in fact relayed to Dr Nadal.

250. The Tribunal found paragraph 6.b.ii of the Allegation not proved.

Paragraph 6.d

6.d.i

251. The Tribunal was required to determine whether, during the relevant period, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to seek advice from Patient D's treating clinicians.

252. For the same reasons as set out in respect of paragraph 5 of the Allegation, the Tribunal did not consider that there was a need or a duty for Dr Nadal to seek advice from Patient D's treating clinicians with regard to repatriation. Dr Nadal and Dr G had made an

informed and adequate decision that the risks to Patient D of repatriation by air ambulance back to the UK were too high. Having made a reasoned conclusion based on the medical information they had, and Dr Nadal and Dr G's prior experience, meant that further discussion with Patient D's treating clinicians was not required.

253. Information was being sought from, and provided by, the hospital in the form of medical reports. Further, the Tribunal reminded itself that Dr Nadal had attempted to speak to Dr O on 5 March 2018 but had only been able to speak to the nurse in charge and, on 6 March 2018, Dr Nadal had spoken to Dr T, another treating cardiologist who had provided information regarding Patient D's condition as previously outlined in this determination.

254. The Tribunal found paragraph 6.d.i of the Allegation not proved.

6.d.ii

255. The Tribunal was required to determine whether, during the relevant period, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to seek advice from a UK cardiologist.

256. The Tribunal was mindful that there was no specific purpose cited in paragraph 6.d.ii of the Allegation as to why it was alleged Dr Nadal should have sought advice from a UK cardiologist.

257. It appeared to the Tribunal that the GMC relied upon the expert opinion evidence of Dr Q to establish a duty on Dr Nadal to seek such advice. Dr Q did not expressly state that Dr Nadal had a duty to contact a UK cardiologist when considering his decision to repatriate Patient D. Dr Q's evidence was that if Dr Nadal had *'been in any doubt as to the benefits of/indications for cardiac catheterisation in such circumstances he should have sought advice from a UK cardiologist'*. However, Dr Nadal's position had never been that catheterisation might not be of benefit to Patient D; his position was that it was safer for Patient D to await catheterisation in Spain and then be transferred back to the UK. Therefore, there was not any failure of duty by Dr Nadal because the circumstances envisaged by Dr Q that would give rise to this duty had not occurred.

258. In his oral evidence, Dr Q said that if he was in Dr Nadal's position, considering the repatriation of Patient D, he would *'speak with a cardiologist I know and trust, someone I know whose opinion I respect… someone whose first language was English, that's what I*

would do'. The Tribunal accepted this was what Dr Q may well have done in Dr Nadal's position to feel more secure in his decision-making. However, Dr Nadal, who is fluent in Spanish, faced no language barrier with the treating clinicians at the hospital. He was familiar, not only with hospital facilities in Spain generally, but specifically the hospital Patient D was being treated at as well as the hospital it was proposed Patient D would be transferred to in Gran Canaria. Dr Nadal, whilst having his reservations about Dr O's approach, he had no reason to doubt the clinical information that was being provided either directly by the treating clinicians or in the medical reports. There was no requirement for Dr Nadal to seek a second opinion from a UK cardiologist on the basis that Dr Q put forward.

259. The Tribunal had raised the possibility with Dr Q that a UK cardiologist might have been able to assist with advice about UK waiting times. Dr Q appeared to agree with this possibility. However, the Tribunal did not, on further consideration, infer that a UK cardiologist would be able to give a definitive indication as to waiting times. Accordingly, the Tribunal decided it was probable that such an indication would only be given following an assessment of Patient D by those who would be responsible for his treatment once he had returned to the UK. The Tribunal considered that it was probable that a UK cardiologist, if consulted, would have said that they would need to review and assess Patient D before advising about waiting times. In these circumstances, the Tribunal considered it unlikely that any UK cardiologist would have been able, or prepared, to give an estimate of the likely waiting time. Therefore, there could be no failing by Dr Nadal in not seeking such information.

260. The Tribunal found paragraph 6.d.ii of the Allegation not proved.

6.d.iii

261. The Tribunal was required to determine whether, during the relevant period, Dr Nadal's decision not to repatriate Patient D was inadequate because he failed to seek advice from an air ambulance company.

262. The Tribunal considered that Dr Nadal had no duty to seek advice from an air ambulance company because his decision not to repatriate Patient D had been reasonable. As at 23 February 2018, Dr Nadal had sufficient information to perform an adequate assessment of the risks/benefits of repatriation to enable him to conclude that repatriation was not in Patient D's best interests for the reasons previously given. The Tribunal accepted

Dr Nadal's evidence that only if a decision for repatriation had been made that he would contact an air ambulance company for advice regarding risks of repatriation.

263. Ultimately, in response to the wishes of Patient D's family, EAF agreed that, if the family wished to organise air ambulance repatriation for Patient D themselves, EAF would provide the necessary information to assist them in this respect. Further, the Senior Manager at EAF had advised Ms D that EAF would contribute to the costs of the repatriation but would not be involved in its planning or completion. This was because it remained EAF's view, based upon their medical team's advice, that the risks to Patient D of repatriation were too great given his cardiac condition and comorbidities.

264. In these circumstances, the Tribunal concluded that there was no duty upon Dr Nadal to seek advice from an air ambulance company at any time.

265. The Tribunal found paragraph 6.d.iii of the Allegation not proved.

Paragraph 6.e

266. The Tribunal, having found the entirety of paragraphs 6.a to 6.d of the Allegation not proved, found paragraph 6.e of the Allegation not proved.

Paragraph 7

267. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate for the reasons alleged in paragraph 7.a to 7.h of the Allegation.

268. Paragraph 7 of the Allegation required an assessment of three telephone calls that Dr Nadal had with Ms D. Two calls took place on 28 February 2018 and the other on 1 March 2018, being the last direct communication between Dr Nadal and Ms D.

269. The Tribunal first considered the context of the communications. Dr Nadal was speaking to Ms D, one of Patient D's daughters, who was concerned, and obviously distressed about her father's health. She believed that Patient D needed to be repatriated back to the UK by air ambulance. In her view, the insurance company had not been sufficiently responsive to what she believed to be Patient D's obvious need for repatriation. She had

formed the belief that Patient D would not survive the waiting time for treatment in Spain. Ms D believed that Patient D would be treated soonest if he was repatriated to the UK.

270. As stated above, Dr Nadal's position was that Patient D's best interests did not lie in repatriation to the UK, rather it was, in his view, safest for Patient D to remain in Lanzarote and be transferred to the Dr Negrin hospital in Gran Canaria for treatment as he was entitled under the EHIC regime. It was Dr Nadal's evidence that in his communications with Ms D, he was seeking to impress upon her the benefits of Patient D remaining in Spain for treatment under the public healthcare system and also the risks to Patient D associated with air ambulance repatriation. Dr Nadal was also seeking to encourage Ms D to get the local clinician(s) to honour their treaty obligations and which he had suspected Dr O was seeking to avoid.

271. Having had regard to the context, the Tribunal went on to consider each sub-paragraph of the allegation separately to determine whether the representations alleged were made, whether they were true/accurate and whether they were inappropriate.

272. The Tribunal then went on to consider whether Dr Nadal's communications with Ms D, in which the representations had been made, were inappropriate, having regard to its conclusions in respect of each sub-paragraph.

Paragraph 7.a

273. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he justified why air transfer to the UK was not possible by giving irrelevant, unsubstantiated and/or exaggerated risks regarding the air environment being:

i. low in pressure;
ii. low in oxygen;
iii. extremely dry;
iv. very high in ozone concentrations;
v. subject to acceleration forces;

274. The Tribunal had regard to the transcript of Dr Nadal's first call with Ms D on 28 February 2018. Dr Nadal had made reference to the above five factors. What the Tribunal

was required to determine was whether reference to those risk factors was irrelevant, unsubstantiated and/or exaggerated.

275. The Tribunal acknowledged that Dr Nadal had accepted in his evidence that his comments as to the risks posed by the air environment being: extremely dry (7.a.iii) and very high in ozone concentrations (7.a.iv) had been overstated.

276. The Tribunal had regard to the evidence of Dr Q and Professor R, both of whom confirmed that there were risks in the air environment relating to it being low in pressure (7.a.i), low in oxygen (7.a.ii) and subject to acceleration forces (7.a.v). The Tribunal therefore concluded that Dr Nadal was referring to recognised risks in the air environment in his conversation with Ms D.

277. However, the Tribunal considered the comments Dr Nadal made in relation to these risks failed to make clear that all of them are, as Dr Q had opined and the Tribunal accepted, capable of being mitigated and negative outcomes arising from air ambulance transfer are rare. Professor R's opinion was that outcomes from air ambulance transfer are *'generally favourable'*.

278. The Tribunal considered that, although Dr Nadal's stated intention had been to convey to Ms D that transfers by air were not risk free, he had overstated the risks of transfer by air ambulance. He had done this by failing to make any reference to the means by which the risk could be mitigated or the fact that negative outcomes from air ambulance transfer were rare. Furthermore, Dr Nadal was presenting a misleading picture to a distressed relative of a patient, who, in any event, was going to have to undergo an air ambulance transfer to Gran Canaria (albeit a flight of shorter duration).

279. The Tribunal concluded that the content of and manner in which Dr Nadal made the observations about the risks of the air environment to Ms D, a lay person, were likely to have given her an exaggerated and unbalanced understanding of the risks of air ambulance transfers. Accordingly, the Tribunal determined that such communication was, in the circumstances, inappropriate.

280. The Tribunal found the entirety of paragraph 7.a of the Allegation proved.

Paragraph 7.b

281. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he claimed that if he approved air transfer and Patient D died enroute, he might face manslaughter charges.

282. The Tribunal confirmed from the transcript that Dr Nadal had made reference to possible manslaughter charges during his first conversation with Ms D on 28 February 2018.

283. The Tribunal bore in mind that at the time of this conversation, as Dr Nadal had explained in his evidence, there was widespread concern within the medical profession in the UK as to possible criminal liability doctors might have to face for decisions they made in respect of patients who subsequently died. This concern arose out of a well-publicised case where a doctor had been convicted of gross negligence manslaughter in a clinical context. The Tribunal accepted that Dr Nadal, rightly or wrongly, genuinely believed that he could face criminal charges if he advised repatriation by air ambulance to the UK when he believed that such repatriation was not in Patient D's best interests and would place Patient D's life at risk. The Tribunal noted that Dr Nadal had said something very similar about the risk of facing a manslaughter charge to Dr T on 6 March 2018.

284. The Tribunal accepted that Dr Nadal, if he considered it necessary to convey his concerns, could have expressed them in a different way. However, in the Tribunal's judgment, he was in effect saying 'if I advise Patient D to be repatriated to the UK, that would be a reckless decision to take because I know the risk that it would present to Patient D'. In these circumstances, the Tribunal accepted that it was not inappropriate for Dr Nadal to express his genuine concern.

285. The Tribunal found paragraph 7.b of the Allegation not proved.

Paragraph 7.c

286. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he provided his personal political views on healthcare within the EU and the UK which had no relevance to Patient D's care.

287. The Tribunal had regard to the transcript of Dr Nadal's first call with Ms D on 28 February 2018. Dr Nadal had expressed views of a political nature regarding healthcare within the EU and UK. He stated that certain EU countries were discriminating and/or prejudiced against British nationals who were entitled to healthcare within the EU because of the UK's, then recent, decision to leave the European Union (Brexit).

288. The Tribunal considered that all of this additional and detailed information, including Dr Nadal's views on the politics of Brexit and the difficulties Brexit was causing in obtaining healthcare in the EU, was not information that Ms D would have wanted or needed to know. It would have been sufficient for Dr Nadal to simply highlight to Ms D that as an EU citizen, Patient D was, at that time, entitled to healthcare in Spain as if he were a Spanish citizen.

289. In his oral evidence, Dr Nadal said that his intention in raising these matters in the way he did was to build up Ms D's sense of entitlement to treatment for her father. By doing so, Dr Nadal hoped to encourage Ms D to challenge the Spanish medical authorities for their apparent failure to comply with their treaty obligations. The Tribunal considered that if this was Dr Nadal's motivation, it was surprising that the first time he referred to this reasoning was during the course of cross-examination and not at any time before, including in his witness statement(s). Further, if this had been his motivation, the Tribunal considered that Dr Nadal could simply have stated clearly and concisely that Patient D was entitled to healthcare under the EU system and Ms D should endeavour to obtain it for Patient D on his behalf.

290. The Tribunal concluded that Dr Nadal's personal political views on healthcare within the EU, particularly as it pertained to Brexit, in the circumstances, were not relevant or helpful to Ms D. It concluded therefore that Dr Nadal's communications in this respect were inappropriate.

291. The Tribunal found paragraph 7.c of the Allegation proved.

Paragraph 7.d

292. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he made disparaging remarks about Spanish private healthcare facilities that '*may not have been*' appropriate.

293. The Tribunal considered that, whereas Dr Nadal had made observations about Spanish private healthcare facilities that could be described as disparaging, paragraph 7.d

was drafted in such a way that it was implicitly alleged that Dr Nadal's observations might have been appropriate. The GMC had not sought to amend this paragraph of the Allegation to address this paradox and the Tribunal did not consider it appropriate to do so of its own volition.

294. Therefore, the Tribunal found paragraph 7.d of the Allegation not proved.

Paragraph 7.e

295. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he made disparaging comments about the input of consular staff and knowledge of aviation medicine of specific nationalities.

296. The Tribunal considered that it would have been more sensible if this paragraph of the Allegation had been in two parts as it related to two distinct matters upon which Dr Nadal had allegedly commented and which did not need to be considered conjunctively.

297. Nevertheless, the Tribunal first considered whether Dr Nadal had made inappropriate disparaging remarks about the input of consular staff to Ms D.

298. The Tribunal had regard to the transcript of Dr Nadal's second conversation with Ms D on 28 February 2018. During the course of their conversation, Dr Nadal said to Ms D:

> [Dr Nadal] *'… You tell me the British embassy is contacting the doctors. Do you have a number or the name or contact at the Foreign and Commonwealth Office or the Embassy in Spain?'*
>
> [Ms D]: *'Yes I do'*
>
> [Dr Nadal]: *'Because what I find is they're frequently extraordinarily either ignorant or they accept as true what they're being told by foreign service providers and they sometimes need to be educated as it were. So who is it you've been speaking to?'*
>
> [Ms D]: *'Her name is* [Ms E]*'*…

299. Whether or not Dr Nadal's observations reflected his experience of consular staff generally, the Tribunal considered that this sweeping statement was denigrating and disparaging of consular staff in general and, as Dr Nadal accepted, had proved to be wrong in relation to Ms E.

300. The Tribunal considered the context of Dr Nadal's conversation with Ms D and why she had raised the possibility of Dr Nadal speaking with Ms E. Ms D was seeking to do everything she could to ensure Patient D received treatment, in so doing, she had contacted the Foreign and Commonwealth Office for support. Dr Nadal's communications, in making such a generalised disparaging remark, was clearly inappropriate in these circumstances.

301. The Tribunal then considered whether Dr Nadal had made inappropriate disparaging remarks about the knowledge of aviation medicine of [Doctors of] specific nationalities.

302. The Tribunal had regard to Dr Nadal's first conversation with Ms D on 28 February 2018 in which Dr Nadal said: *'Lots of doctors around the world know so little about aviation medicine. They don't even know there's anything to know. In Spain, they tend to know a little bit. In Italy, they know nothing at all, it's amazing…'* Ms D, unsurprisingly, responded by saying *'I'm not interested in all of that…'*.

303. Further, the Tribunal considered that although these remarks might be characterised as a passing or flippant remark made during the course of an otherwise lengthy and detailed conversation, it was plainly disrespectful and disparaging to doctors of specific nationalities. In particular, the Tribunal considered that the suggestion that (all) doctors in Italy *'know nothing at all'* (about aviation medicine) was patently absurd and disparaged all Italian doctors.

304. The Tribunal considered that this statement was not only absurd, but it was irrelevant and unnecessary. Further, the Tribunal considered that the irrelevance of this statement was well illustrated by Ms D's response to it. The Tribunal concluded that such disparaging remarks were also plainly inappropriate in the context of Dr Nadal's conversation with Ms D.

305. The Tribunal, having found that Dr Nadal's remarks were inappropriate regarding consular staff and the knowledge of aviation medicine of specific nationalities, concluded that both separate aspects of paragraphs 7.e of the Allegation were proved.

Paragraph 7.f

306. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he stated that delays for cardiac intervention in the UK were the worst in Europe.

307. The Tribunal had regard to the transcript of Dr Nadal's first call with Ms D on 28 February 2018. Dr Nadal said *'The delays in the United Kingdom are unsurpassed anywhere else in Europe'*.

308. The Tribunal considered that, even if this statement had been correct (Dr Nadal appeared to accept that it was not, at least insofar as he acknowledged that delays in Eastern Europe for cardiac intervention were worse), this was a further example of a generalised statement being made by Dr Nadal and which purported to encompass all cardiac provision within the UK.

309. The Tribunal considered that if, as Dr Nadal asserted, he was making this comment with a view to highlight that Patient D would most likely be treated sooner in Spain than in the UK, he could have done so using more appropriate and accurate language. Given the context of the conversation and the lack of substantiation for Dr Nadal's statement, the Tribunal concluded that this communication was inappropriate.

310. The Tribunal found paragraph 7.f of the Allegation proved.

Paragraph 7.g

311. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he mentioned other cases of repatriation in which the patient died.

312. The Tribunal had regard to the transcript of Dr Nadal's second conversation with Ms D on 28 February 2018. Dr Nadal said:

> *'…And that's why the aviation environment is so inimical to everyone's interest. The other thing which you might be interested to know is that until about 2 and a half years ago, perhaps 3 now, we used to move people back to England when they were in a certain jurisdiction, so for example Greece, or you know wherever and America as*

well… But what we found is about three years ago, we had some really terrible cases in which people who had deteriorating left ventricular function, that's the main pumping chamber of the heart…We know in the United Kingdom, lots of people aren't surviving and so we know from Greece as a country in particular where over the last year for example, we have had lots of people with severe ischaemic heart disease, on principal we don't bring them back and the reason is they come back here and many never ever get to the front of the queue… here it is routine to be waiting for months and it is known as a fact that many people die waiting. I mean it's just a fact.'

[Ms D]: *'I completely completely support him having the treatment in Gran Canaria'*

[Dr Nadal]: *'But you don't support him not having the treatment, that's the point'.*

313. The Tribunal reminded itself that Dr Nadal was speaking to Ms D, who was concerned that her father should receive treatment for his heart condition, whether that took place in Spain or in the UK and she feared that, without which, her father would die. Dr Nadal was aware of Ms D's concerns and of her obvious distress. It was for this reason that he had been specifically asked to speak to Ms D.

314. The Tribunal concluded that Dr Nadal sharing these observations about other patients who had been repatriated and subsequently died were not only unnecessary but were insensitive to Ms D's situation. It considered that this was no way to communicate with someone in her position and his observations were likely to cause her more distress and this should have been obvious to Dr Nadal.

315. Accordingly, the Tribunal determined that Dr Nadal's references to other cases of repatriation where patients had died was inappropriate and insensitive.

316. The Tribunal found paragraph 7.g of the Allegation proved.

Paragraph 7.h

317. The Tribunal was required to determine whether, on 28 February and 1 March 2018, Dr Nadal's communication with Ms D was inappropriate because he stated that the UK government delayed issuing Provisional Replacement Certificate (PRC) to reduce costs.

318. The Tribunal had regard to the transcript of Dr Nadal's third call with Ms D on 1 March 2018. Dr Nadal said to Ms D:

> *'…I'm just trying to explain the whole picture to you… the costs to the British government of all the treatment abroad is so high, they're trying to reduce it and they're then restricting by various unlawful means in addition, interpreting law is completely and regulations completely unreasonably in a way that no court would support. They're sometimes not issued PRC's so they're often delayed…'*

319. The Tribunal bore in the mind that by the time of this call with Ms D, Dr Nadal had already spoken with Ms E, the consular official and knew that all issues regarding Patient D's EHIC card and PRC had been resolved by Ms E.

320. Dr Nadal's observations about his belief that the British government were deliberately delaying the issuing of PRCs to reduce costs and were, in his opinion, acting unlawfully, and interpreting the law unreasonably, were plainly irrelevant because at the time of his conversation with Ms D he knew, having very recently spoken to Ms E, that the PRC issue had been resolved.

321. The Tribunal concluded that Dr Nadal's statements on this matter were, even if true, entirely irrelevant.

322. The Tribunal found paragraph 7.h of the Allegation proved.

<u>The stem of Paragraph 7</u>

323. Having found paragraphs 7.a, 7.c, 7.e, 7.f, 7.g and 7.h proved, the Tribunal went on to consider whether, taken together, Dr Nadal's communications with Ms D were as alleged in the stem of paragraph 7 inappropriate.

324. The Tribunal again reminded itself of the context of the three conversations Dr Nadal had with Ms D. It acknowledged that the first ended because Dr Nadal had to attend a meeting, the second ended on a conciliatory note and the third concluded acrimoniously. Ms D terminated the third call by hanging up on Dr Nadal as he was giving yet further unwanted explanation as to the provision for healthcare within the EU under the EHIC regime.

325. The Tribunal had regard to the provisions of GMP in respect of communication. In particular, is considered paragraphs 32 and 33:

> ***32*** *You must give patients[20] the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
>
> > *20 Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.*
>
> ***33*** *You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.*

326. The Tribunal considered that taking the sub-paragraphs it had found proved together, and when considering the principles of GMP, Dr Nadal had failed to provide information that Ms D wanted and/or needed to know in a way that she could, as a lay person, understand. He had also failed to consider how some of his comments could have increased Ms D's already apparent distress at the situation Patient D and his family were facing.

327. The Tribunal determined that the overall content, and tenor, of Dr Nadal's conversations with Ms D as found proved in paragraphs 7.a, 7.c, 7.e, 7.f, 7.g and 7.h fell outwith the requirements of GMP. Accordingly, it determined that Dr Nadal's communication with Ms D as alleged in the stem of paragraph 7 of the Allegation was inappropriate.

328. The Tribunal found the stem of paragraph 7 of the Allegation proved in respect of sub-paragraphs 7.a, 7.c, 7.e, 7.f, 7.g and 7.h.

Paragraph 8

329. The Tribunal was required to determine whether on 1 or 2 March 2018, Dr Nadal's communication with Ms E had been inappropriate in that his attitude was condescending and unhelpful.

330. The Tribunal identified that the material evidence upon which the GMC relied for paragraph 8 of the Allegation was limited to two documents admitted as hearsay evidence. First, Ms E's near contemporaneous consular record of a summary of her discussion with Dr Nadal, which Ms E had relayed to Ms D. Second, an email dated 5 June 2018, in which Ms E

provided some further detail of her recollection of her discussion with Dr Nadal. Ms E was not called to give evidence on behalf of the GMC.

331. In the FCO log, in response to an email from Ms D which characterised Dr Nadal as *'exceptionally pompous and patronising'*, Ms E wrote *'I have called* [Ms D] *and clarified what I spoke to Dr Nadal earlier'*. The summary of the conversation that followed did not comment or make any observation upon Dr Nadal's attitude, in particular, there was no reference to Dr Nadal being either condescending or unhelpful.

332. In her email dated 5 June 2018, Ms E set out some further specifics of her recollection of her conversation with Dr Nadal:

> *'Dr. Nadal called after having spoken to* [Ms D] *who provided him with my contact details. He started off the conversation quite rudely and stating that I was an "ignorant", despite not having crossed one single word with me previously nor being aware of my healthcare policy and customer service experience having worked for the Department of Health before at the British embassy in Madrid for over a year. He seemed to assume I had no knowledge of how the Spanish public and private healthcare system works and therefore started off giving me a lesson on the European Health Insurance Card, European healthcare policy, information on his career background, studies and experience…*
>
> *At some point later I managed to interrupt his speech and made it clear that I have a great knowledge on European healthcare policy, British and Spanish and the bilateral healthcare policies between these countries, specifically on public healthcare cover and resources provided at Spanish and British public healthcare systems, more specifically on public and private hospitals in the province of Las Palmas where I now work as Consular Officer…'*

333. In terms of what weight, if any, the Tribunal could attribute to this hearsay evidence, the Tribunal bore in mind the dates of the respective records and the purpose for which they were apparently created. Ms E's record on 1 March 2018, was an official log of her interactions with Ms D and Dr Nadal that day, it was a near contemporaneous and professional record. Her email on 5 June 2018, followed interactions between Ms D, Ms E and Mr A, the son of Patient A, who had been the subject the Allegation at paragraph 1 (an allegation dismissed at the close of the GMC's case) who was seeking information about EAF and Dr Nadal.

334. The Tribunal noted that in neither of these records created by Ms E, did she explicitly characterise Dr Nadal as having a condescending and unhelpful attitude. The Tribunal acknowledged that it may have been a possible inference to be drawn from Ms E's description of her conversation contained within her email of 5 June 2018. However, the Tribunal considered that it was unable to draw any such inference in the absence of any direct evidence from Ms E and where there had been no opportunity for her recollection of her conversation with Dr Nadal to be tested. The Tribunal considered itself unable to attach sufficient weight to the hearsay evidence such that it could find paragraph 8 of the Allegation proved on the balance of probabilities.

335. The Tribunal further noted that unlike the conversations that it had considered in relation to paragraphs 4 and 7 of the Allegation, it had not had the advantage of considering a transcript or recording of the conversation which was the subject of the allegation. In these circumstances, it had been far less able to assess the tone or quality of the conversation. The Tribunal noted Dr Nadal's description or perception of his conversations with Ms E was very different than that which the GMC had alleged to be Ms E's assessment in paragraph 8 of the Allegation. Dr Nadal had, in terms, described his conversation with Ms E as having been cordial, good-natured and positive. The Tribunal also noted that this perception was reflected in his comments made to Ms D, in his conversation with her on 1 March 2018, as was apparent from the transcript of that conversation.

336. Therefore, the Tribunal found paragraph 8 of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

337. The Tribunal has determined the facts as follows:

~~Patient A~~

~~1. On 16 March 2016 your decision not to repatriate Patient A was inadequate in that you failed to:~~

~~a. ascertain the level of care being provided at the host hospital ('Myung Sung Medical Centre') in respect of:~~

~~i. medical and nursing staff;~~

~~ii. clinical facilities;~~
~~iii. cleanliness;~~
~~iv. treatment options available;~~

~~b. ascertain whether a better level of care could be provided on the African sub-continent resulting in reduced transfer times;~~

~~c. adequately assess the risk versus benefit of aeromedical transfer taking into account the factors as set out in paragraphs 1.a and/or 1.b.~~

Deleted in its entirety following successful 17(2)(g) application

Patient B

2. Between 30 June and 9 July 2017, your ongoing decision-making relating to the repatriation of Patient ~~XX~~ B was inadequate in that you failed to:
Amended under Rule 17(6)

a. obtain any medical information regarding Patient B's clinical condition until 7 July 2017;
Not proved

b. have the Turkish medical report received on 4 July 2017 translated in the UK;
Not proved

c. monitor Patient B's treatment and progress at the host hospital ('Yucelen Hospital Mugla');
Determined and found proved

d. discuss Patient B's case with:

i. his UK Consultant Haematologist ('Dr C') to utilise the specialist advice being offered to you;
Determined and found proved

ii. an air ambulance company for advice about the risks of repatriation;
Not proved

e. pursue early aeromedical repatriation having regard to:

i. Patient B having a complex, rare and life-threatening condition that required specialist care;
Determined and found proved

ii. the necessary clinical expertise on Patient B's condition not being available at the host hospital;
Determined and found proved

~~iii. the host hospital and / or treating clinician being reluctant to facilitate Patient B's transfer to the state hospital ('Mugla State University Hospital').~~
Deleted following successful 17(2)(g) application

3. From 5 July 2017 onwards, your care of Patient B was inadequate in that you failed to:

a. ensure the telephone calls from Patient B's family were returned in a timely manner;
Not proved

b. return Dr C's telephone calls.
Not proved

4. On 10 July 2017, your communication with Patient B's family was inappropriate in that:

a. your attitude was uncaring and unprofessional;
Not proved

b. you gave advice about blood transfusion which served no purpose;
Not proved

c. you shared an unprofessional opinion about:

i. Dr C's letter dated 5 July 2017 being very unhelpful to you;
Determined and found proved

ii. the ability of Worthing Hospital to manage Patient B's condition effectively;
Determined and found proved

~~d. you did not end your conversation with a definitive plan:~~

~~i. about the transfer;~~

~~ii. when you would contact Patient B's family again and /or when further contact would be made.~~
Deleted following successful 17(2)(g) application

Patient D

5. Between 28 February and 4 March 2018, your care of Patient D was inadequate in that you failed to make any direct contact with the treating clinician to monitor Patient D's clinical condition and progress.
Not proved

6. From 21 February 2018 onwards, your decision not to repatriate Patient D was inadequate in that you failed to:

a. have sufficient regard to the fact Patient D:

i. had suffered a major cardiac event on the background of chronic cardiac disease;
Not proved

ii. had a life-threatening condition;
Not proved

iii. did not initially have a rapidly deteriorating condition;
Not proved

iv. would likely need to wait at least a month for cardiac catheterisation locally;
Not proved

~~v. would require helicopter transfer to another island for cardiac catheterisation at the Dr Negrin Hospital~~;
Deleted following successful 17(2)(g) application

b. have sufficient regard to the treating clinicians view that Patient D:

i. required urgent catheterisation with or without treatment;
Not proved

ii. would die without cardiac catheterisation, as related to you by the Consulate Representative (Ms E);
Not proved

~~c. have sufficient regard to the limited cardiology facilities at the host hospital ('General Hospital Arricefe')~~
Deleted following successful 17(2)(g) application

d. seek advice from:

i. the treating clinicians;
Not proved

ii. a UK cardiologist;
Not proved

iii. an air ambulance company;
Not proved

e. adequately assess the risk versus benefit of aeromedical transfer by taking into account the factors as set out in paragraphs 6.a to 6.d.
Not proved
Deleted following successful 17(2)(g) application in respect of paragraph 6.a.v and 6.c

7. On 28 February and 1 March 2018, your communication with Patient D's family was inappropriate in that you:

a. justified why air transfer to the UK was not possible by giving irrelevant, unsubstantiated and / or exaggerated risks regarding the air environment being:

   i. low in pressure;
   Determined and found proved
   ii. low in oxygen;
   Determined and found proved
   iii. extremely dry;
   Determined and found proved
   iv. very high in ozone concentrations;
   Determined and found proved
   v. subject to acceleration forces;
   Determined and found proved

b. claimed if you approved air transfer and Patient D died enroute, you might face manslaughter charges;
Not proved

c. provided your personal political views on healthcare within the EU and the UK which had no relevance to Patient D's care;
Determined and found proved

d. provided observations about Spanish private health care facilities that may not have been appropriate;
Not proved

e. made disparaging remarks about the input of Consular staff and knowledge of aviation medicine of specific nationalities;
Determined and found proved

f. stated delays for cardiac intervention in the UK were the worst in Europe;
Determined and found proved

g. mentioned other cases of repatriation in which the patient died;
Determined and found proved

h. stated that the UK government delayed issuing Provisional Replacement Certificate to reduce costs;
Determined and found proved

~~i. failed to provide any degree of reassurance to the family concerns or that you were acting in Patient D's best interests.~~
Deleted following successful 17(2)(g) application

8. On 1 or 2 March 2018, your communication with Ms E was inappropriate in that your attitude was condescending and unhelpful.
Amended under Rule 17(6)
Not 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 - 24/07/2023

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Nadal's fitness to practise is impaired by reason of misconduct.

The Outcome of Applications Made during the Impairment Stage

2. The Tribunal refused the application for Voluntary Erasure (VE) made on behalf of Dr Nadal, pursuant to the GMC (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations Order of Council 2004/2609 (VE Regulations). The Tribunal's full decision on the application is included at Annex F.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, on behalf of Dr Nadal, the Tribunal received further documentary evidence as follows:

- A statement of personal reflections from Dr Nadal, dated July 2023;
- A template letter used by Dr Nadal's solicitors when requesting a testimonial, enclosing the draft Allegation;
- Testimonials from colleagues, neighbours and friends of Dr Nadal, various 2022 and 2023 dates.

Submissions

On behalf of the GMC

4. On behalf of the GMC, Ms Kitzing submitted that Dr Nadal's fitness to practise is impaired by reason of misconduct. She referred the Tribunal to its factual findings and the paragraphs of Good Medical Practice (2013) (GMP) it had previously identified as relevant to its consideration of the case. Ms Kitzing submitted that Dr Nadal's breaches of GMP were numerous, varied and were an important factor indicating that serious professional misconduct had occurred. She submitted that each of the Tribunal's findings of fact individually amounted to serious misconduct so there would be no need to consider the individual findings cumulatively.

5. In respect of impairment, Ms Kitzing submitted that Dr Nadal's conduct had in the past put patients at unwarranted risk of harm, had brought the medical profession into disrepute and had breached fundamental tenets of the medical profession.

6. Ms Kitzing submitted that Dr Nadal had not displayed insight throughout this hearing. She submitted that the Tribunal was entitled to consider how Dr Nadal's case had been conducted in its assessment of insight. Ms Kitzing referred the Tribunal to his reflective statement and acknowledged that Dr Nadal has now shown acceptance of the Tribunal's findings and shown some awareness of the need to work collaboratively with colleagues and improve communication with patients and their families. She submitted that Dr Nadal has only recently begun to gain insight into his misconduct. Ms Kitzing submitted that without the development of greater insight and remediation, the Tribunal could not be satisfied that serious misconduct would not be repeated.

7. Ms Kitzing submitted that a finding of impairment was necessary in this case to uphold all three limbs of the overarching objective.

On behalf of Dr Nadal

8. On behalf of Dr Nadal, Mr Geering submitted that Dr Nadal's fitness to practise was not currently impaired.

9. In respect of the Tribunal's factual findings, Mr Geering submitted that it would be inappropriate to cumulate the various failings which have been found proved. He submitted that there is nothing unusual about Dr Nadal's case to justify adopting a cumulative approach. Mr Geering submitted that it was relevant that the GMC had never presented its case on the basis that only cumulatively could Dr Nadal's conduct amount to serious misconduct.

10. Mr Geering submitted that it would be inappropriate to cumulate findings in relation to Dr Nadal's communications with Ms D that the Tribunal found to be inappropriate. He submitted that there was a distinction between the Tribunal's findings that Dr Nadal failed to convey information appropriately and its findings that some of Dr Nadal's comments could have caused heightened distress to Ms D. He submitted that Dr Nadal had not intended to cause distress, that this had not been alleged and he reminded the Tribunal of the context of Dr Nadal's phone calls with Ms D. Mr Geering submitted that a number of the proven sub-paragraphs of paragraph 7 could not amount to misconduct because whilst some of Dr Nadal's comments may have been unprofessional and unhelpful, they were not all likely to have caused distress.

11. Mr Geering stated that Dr Nadal had accepted the Tribunal's findings that identified serious failings in his practice regarding Patient B. He submitted that consideration of any future risk, based on this single case, could only be done in the context of Dr Nadal's long career where he had advised upon thousands of cases. Mr Geering submitted that the risk of repetition was low because Patient B's case was highly unusual, and the failings found were not an accurate representation of the quality of the day to day work Dr Nadal had conducted for years without incident. Mr Geering submitted that the issues identified with Dr Nadal's communication arose from conversations in 2018. He submitted that Dr Nadal has spoken to many other policyholders since and no other instances of poor communication have been raised.

12. Mr Geering acknowledged that Dr Nadal's insight was not complete but submitted that insight can take a number of forms. He submitted that Dr Nadal has attended and engaged with these proceedings and shown respect to his regulator and this Tribunal

throughout. Mr Geering submitted that Dr Nadal has appropriately reflected on the findings of the Tribunal and will continue to do so. He submitted that Dr Nadal knows he has damaged the reputation of the profession, and that his actions have undermined the public's faith in him, his colleagues and the wider profession. Mr Geering referred the Tribunal to Dr Nadal's reflection and submitted that he had reflected on the impact of his actions on the families of Patient B and Patient D. Dr Nadal has accepted that his poor communication heightened their distress. Mr Geering invited the Tribunal to take account of the positive testimonials provided on Dr Nadal's behalf that attest to his compassion, diligence and sincerity.

13. Turning to the public interest, Mr Geering submitted that the public would have regard to all of the relevant factors, including the time elapsed since the events and the lack of repetition. He submitted that the fact of these proceedings had adequately upheld the public interest. Mr Geering submitted that Dr Nadal would end his career of 41 years with a finding of serious professional misconduct. He submitted that in the circumstances of this case, a finding of impairment was unnecessary and would be disproportionate.

The Relevant Legal Principles

14. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgment alone.

15. In approaching the decision, the Tribunal was mindful of the two stage process to be adopted: first whether the facts as found proved amounted to misconduct and that the misconduct was serious. Second, whether the finding of misconduct that was serious could lead to a finding of impairment.

16. The Tribunal must determine whether Dr Nadal's fitness to practise is impaired today, taking into account his 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.

The Tribunal's Determination on Impairment

17. The Tribunal heard submissions on, and had regard to, the cases of *Schodlok v GMC* [2015] EWCA Civ 769 (Admin) and *Ahmedsowida v GMC* [2021] EWHC 3466 (Admin) which set down the limited circumstances in which it can be appropriate for a Tribunal to aggregate

findings of misconduct, which do not, in and of themselves amount to serious misconduct, to find serious misconduct when those findings are considered together.

18. The Tribunal considered that it was appropriate to consider its findings in respect of paragraphs 2, 4 and 7 of the Allegation separately and in isolation when determining whether the facts found proved amounted to misconduct, and whether that misconduct was serious. Accordingly, the Tribunal determined that, in the event that it found misconduct, but not *serious* misconduct in relation to any single paragraph, it would not be appropriate to aggregate its findings on paragraphs 2, 4 and/or 7 of the Allegation to reach a conclusion of serious misconduct.

19. As noted above, it was submitted by Mr Geering, on behalf of Dr Nadal, that the Tribunal should consider each sub-paragraph of the Allegation found proved in isolation and determine whether each amounted to serious misconduct individually. He submitted that it would not be appropriate to aggregate, for example, sub-paragraphs of paragraph 7 of the Allegation, to reach a conclusion that paragraph 7, as a whole, amounted to serious misconduct.

20. The Tribunal did not accept Mr Geering's submission. It considered that the stem of each paragraph of the Allegation amounted to a single episode of misconduct and the sub-paragraphs merely identified the particulars of the episode of misconduct alleged in the stem.

21. The Tribunal considered each paragraph of the Allegation and its proven sub-paragraphs in turn in determining whether the facts found proved, or any of them, amounted to misconduct and whether that misconduct was serious.

Misconduct

Paragraph 2

22. The Tribunal reminded itself of its findings. It had determined that Dr Nadal's decision-making in respect of Patient B was inadequate in that:

- Dr Nadal had failed to monitor Patient B's treatment and progress at the host hospital;

- He failed to discuss Patient B's case with his treating UK Consultant Haematologist, Dr C, who was offering specialist advice;
- He failed to pursue early aeromedical repatriation despite Patient B having a complex, rare and life-threatening condition that required specialist care that could not be provided by the host hospital.

23. The Tribunal had found that by no later than 6 July 2017, Dr Nadal knew, or should have known, that Patient B had a complex, rare and life-threatening condition and that he was deteriorating at the host hospital. The Tribunal considered that Dr Nadal should have taken all necessary and appropriate steps to effectively monitor Patient B's treatment and progress in an attempt to facilitate the most favourable outcome for Patient B and that Patient B's family would have had a reasonable expectation that Dr Nadal would do so. Dr Nadal should, at that time, have appreciated that a failure to do so could have had serious consequences for Patient B.

24. The Tribunal continued to be mindful that it had not been alleged, and it had not found, that Dr Nadal's failings had caused or contributed to the death of Patient B. However, the proven failings relating to Dr Nadal's inadequate decision-making had potentially deprived Patient B of an opportunity to receive expeditious and effective treatment that might have resulted in a different outcome for him. The Tribunal was of the view that the gravity of Dr Nadal's failings as found proved in respect of paragraph 2 of the Allegation should not be understated.

25. The Tribunal acknowledged that the failings found proved in respect of paragraph 2 of the Allegation related to a single patient and could, to that extent, be considered to be an isolated incident. However, in the Tribunal's judgment, this was not a single failing, it was a multi-faceted episode that included a failure to effectively monitor Patent B's treatment and progress at the host hospital, to access expert advice available and to use this information to inform his decision on early aeromedical repatriation. There were a series of failings over a number of days where Dr Nadal failed to act appropriately despite clear and numerous indications that Patient B was seriously unwell, deteriorating and might die without specialist care.

26. The Tribunal considered that Dr Nadal's failings in regard to Patient B were aptly illustrated by his complete failure to utilise the expertise of Dr C. Having read his letter on or about 6 July 2017, Dr Nadal knew Dr C was ready and available to give advice. The Tribunal had determined that, rather than seeking the specialist advice being offered by Dr C, Dr

Nadal was wholly dismissive of him, without any good reason. It appeared that Dr Nadal's attitude towards Dr C was borne of an unreasonably held belief that all UK doctors would always recommend repatriation and that he, Dr Nadal, knew better than them. The Tribunal considered that on the information available to him, coupled with the fact that Dr Nadal had said he *'did not know what to do'*, it was astonishing that he had made no attempt to contact Dr C at any stage.

27. The Tribunal also had regard to the expert opinion of Dr Q who set out that in failing to make contact with Dr C, Dr Nadal's actions fell seriously below the standard expected and may have materially and adversely influenced the decision not to organise an early repatriation.

28. The Tribunal considered that Dr Nadal's failures in decision-making went to the heart of what it means to be a good doctor and involved significant breaches of Good Medical Practice (2013) (GMP). Dr Nadal's failings breached the following paragraphs of GMP:

> *'**4** You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.*
>
> ***7** You must be competent in all aspects of your work, including management, research and teaching.*
>
> ***14** You must recognise and work within the limits of your competence.*
>
> ***35** You must work collaboratively with colleagues, respecting their skills and contributions.'*

29. Patient B had a rare and life-threatening haematological condition that required the input of a haematologist. Dr Nadal was not a practising clinician, much less was he a specialist in haematology. Dr Nadal had failed to appropriately exercise judgement and recognise the limits of his own competence by not seeking further information about Patient B's care and by failing to utilise the specialist advice Dr C was offering to him. These failings potentially had serious consequences for Patient B.

30. Taking into account the seriousness of Dr Nadal's repeated failings during the course of his involvement with Patient B's case, the identified breaches of GMP and the conclusion of Dr Q, the Tribunal found that Dr Nadal's actions as found proved at paragraph 2 of the Allegation amounted to misconduct and that the misconduct was serious.

Paragraph 4

31. The Tribunal reminded itself of the context of the communication between Dr Nadal and Ms BB. At the time of the conversation, Ms BB was deeply concerned and anxious about the welfare of her husband. She was acutely aware of his complex, rare and life-threatening condition, that he was abroad in Turkey, and that she had informed the insurers and Dr Nadal that he was not receiving adequate treatment at the host hospital. She was seeking help and assistance from Dr Nadal for Patient B.

32. The Tribunal was in no doubt, as it had already found, that the observations Dr Nadal made about Dr C's letter and the ability of Worthing Hospital to treat Patient B were inappropriate and pejorative. They should not have been said, particularly given the context for Ms BB's call. In the call with Ms BB, Dr Nadal denigrated Dr C and the hospital that had had a responsibility for Patient B's care.

33. The Tribunal considered that in sharing unprofessional and wholly unsubstantiated opinions about Dr C's letter and Worthing Hospital, Dr Nadal's conduct had engaged paragraphs 35 (set out above) and 36 of GMP:

> *'36 You must treat colleagues fairly and with respect.'*

34. However, the Tribunal had regard to the tone of the conversation, of which it had heard a recording. Further, it reminded itself of Ms BB's evidence that she, in a number of other respects, had been reassured by her conversation with Dr Nadal. Ms BB's evidence was not that she had taken any particular offence to the observations made by Dr Nadal regarding Dr C's letter or Worthing Hospital.

35. The Tribunal concluded that making pejorative and what might described as flippant comments was, in the circumstances, ill-advised on Dr Nadal's part and therefore amounted to misconduct. However, as Dr Nadal's comments had not caused Ms BB additional distress and in the judgment of the Tribunal, were not intended to cause offence, it found that they did not amount to misconduct that was serious.

Paragraph 7

36. In its facts determination, having considered each sub-paragraph of paragraph 7 of the Allegation separately, the Tribunal then considered whether the stem of paragraph 7, that Dr Nadal's communications with Ms D were inappropriate, was proved. The Tribunal had already determined that the overall content, and tenor, of Dr Nadal's conversations with Ms D as found proved in paragraphs 7.a, 7.c, 7.e, 7.f, 7.g and 7.h fell outwith the requirements of GMP. Accordingly, it determined that Dr Nadal's communication with Ms D was inappropriate.

37. The Tribunal considered, as it had already found proved, that Dr Nadal's communications with Ms D were inappropriate in a number of respects, and they were made in such a way that caused Ms D anger, frustration and further distress at a time when she was obviously concerned about the welfare of her father who was seriously unwell abroad.

38. Having had regard to the content and context of Dr Nadal's communications with Ms D, the Tribunal considered each sub-paragraph of paragraph 7 in turn.

39. The Tribunal had regard to its findings in respect of sub-paragraph 7.a of the Allegation. The Tribunal bore in mind that Dr Nadal had accepted in evidence that his comments to Ms D about the risks posed by the air environment being: extremely dry (7.a.iii) and very high in ozone concentrations (7.a.iv) had been overstated. It also bore in mind its finding that whilst Dr Nadal had referred to recognised risks in the air environment, he had failed to make clear that all were capable of being mitigated, as Dr Q had confirmed. Further, Professor R, the expert witness instructed on Dr Nadal's behalf, had confirmed in his report that outcomes from air ambulance transfer are *'generally favourable'*.

40. The Tribunal further concluded that Dr Nadal's comments to a distressed Ms D had the potential to mislead her as to the risks of the air environment. These inappropriate comments were likely to cause anxiety and distress, particularly in circumstances where Dr Nadal knew that Patient D would be transferred by air, either to Gran Canaria or the UK, in any event. Dr Nadal had exaggerated the risks of the air environment in an attempt to influence Ms D's decision-making without considering the possible impact or implications of his comments.

41. The Tribunal considered that Dr Nadal's inappropriate communications in this respect breached paragraphs 31, 32 and 33 of GMP:

> '***31*** *You must listen to patients, take account of their views, and respond honestly to their questions.*
>
> ***32*** *You must give patients[20] the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.*
>
> (Footnote 20) *Patients here includes those people with the legal authority to make healthcare decisions on a patient's behalf.*
>
> ***33*** *You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.'*

42. The Tribunal bore in mind that Dr Nadal's inappropriate communications took place over a limited period of time (two days) with a single member of Patient D's family. However, even taking the comments found proved at sub-paragraph 7.a of the Allegation in isolation, it found that they had been grossly insensitive and were apt to mislead Ms D who was already highly distressed. Accordingly, the Tribunal found Dr Nadal's communications in this regard amounted to misconduct and that misconduct was serious.

43. The Tribunal then considered sub-paragraph 7.g of the Allegation. It had regard to its findings that Dr Nadal's communications, in referring to other cases of repatriation in which a patient had died to Ms D, had been unnecessary, inappropriate and insensitive and had been likely to cause her further distress. It had found that this should have been obvious to Dr Nadal and he therefore should have avoided making such comments, particularly in circumstances where he knew Ms D believed that Patient D, her father, was going to die if he was not repatriated home. The Tribunal concluded that this comment constituted a breach of paragraph 33 of GMP. Further, the Tribunal determined that this inappropriate comment amounted to misconduct and having regard to the circumstances in which it was made it was misconduct that was serious because of its obvious potential to cause Ms D further distress.

44. In considering sub-paragraphs 7.c, 7.e, 7.f and 7.h of the Allegation, the Tribunal reminded itself of Dr Nadal's specific comments and Ms D's reactions. The Tribunal had found that Dr Nadal's inappropriate comments had ranged from being irrelevant and unhelpful to

absurd and disparaging. It concluded that these comments amounted to misconduct. However, it considered that whilst the comments made were misguided, they did not of themselves amount to serious misconduct.

45. Accordingly, the Tribunal found serious misconduct in respect of sub-paragraphs 7.a and 7.g of the Allegation and not in sub-paragraphs 7.c, 7.e, 7.f and 7.h.

46. The 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 Ms D regarding the risks of the air environment and his comments about other cases of repatriation where the patient had died.

47. 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 Ms D represented further serious breaches.

48. The 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.

49. Accordingly, the 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.

Impairment

50. The Tribunal having found that some of the facts found proved amounted to misconduct that was serious, went on to consider whether, as a result Dr Nadal's fitness to practise is currently impaired.

Insight

51. In considering impairment, the Tribunal first considered Dr Nadal's remorse, reflection and level of insight.

52. It had not been submitted by either party that Dr Nadal had complete insight into his failings. However, the Tribunal was satisfied that the apologies and remorse set out in his

written reflections were heartfelt and genuine. Dr Nadal has 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.

53. Despite Dr Nadal having appropriately reflected on the impact of his actions and expressing genuine remorse for the distress he had caused, the Tribunal found little evidence of insight into his responsibilities as a registered medical practitioner performing the role of an 'Assistance Medic'. He owed a duty to policyholders who had fallen ill abroad as well as a duty to his principal, the insurers. Dr Nadal had not sufficiently reflected on why his decision-making was inadequate or why he had failed to act with the necessary urgency in Patient B's case.

54. The Tribunal considered that Dr Nadal had not been able to apply paragraph 14 of GMP to his own work as a registered medical practitioner with a licence to practise performing the role of an 'Assistance Medic'. Dr Nadal had, in the course of his evidence, acknowledged that he was not an expert, much less was he in clinical practice treating patients. However, as the events relating to Patient B demonstrated, he relied upon his own assessment of Patient B's treatment needs without any acknowledgement of the limitations of his knowledge and the need to refer to specialist advice, particularly as that advice was being offered to him by Dr C, a UK Consultant Haematologist and Patient B's treating clinician.

55. The Tribunal found that Dr Nadal continued to lack sufficient insight into his duties as a doctor and the requirements placed on him as a registered medical practitioner. It had been advanced in legal argument during the course of the facts stage that Dr Nadal, in his capacity as an 'Assistance Medic' did not owe a duty to the policyholders; his duty was owed solely to his principal, the insurer. In evidence, Dr Nadal did not put it as highly as that, but it was plain throughout his evidence to the Tribunal that he considered any duty owed to the policyholder to be secondary to that owed to the insurer. The Tribunal acknowledged that this was a defence that Dr Nadal was entitled to advance without fear that it would be used against him at any subsequent stage of the proceedings. However, the Tribunal found little evidence that since its determination on facts in April 2023, that Dr Nadal had reconsidered or reflected on his views in this regard.

56. The Tribunal considered that Dr Nadal's fixed views clearly impacted on his decision-making. Whilst he is a highly intelligent and knowledgeable doctor, he has demonstrated a marked inability to appreciate that, on occasion, he might be wrong and the importance of seeking out support in the form of additional information or specialist advice on matters outwith his knowledge and experience.

57. The Tribunal was of the view that Dr Nadal had placed too much weight on what he thought he knew and assumed that knowledge was applicable to scenarios that had a degree of uncertainty. The uncertainty should instead have prompted Dr Nadal to make further enquiries and, where necessary, seek assistance from others. This featured most prominently in Dr Nadal's attitude towards Dr C and in his communications with Ms D.

58. Accordingly, the Tribunal considered that 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.

Remediation

59. Dr Nadal had not completed any specific remediation for his misconduct. In his written reflection, Dr Nadal had stated:

> *'Whilst I would like to make amends for my actions I am now in my later years and have effectively retired from any type of medical activity…I would of course have been willing to undertake any remedial activity but that would be an artificial exercise as my professional life has ceased permanently.'*

60. The Tribunal accepted that Dr Nadal had already taken the decision to retire and that he was genuine in stating that he has no intention of returning to employment as an 'Assistance Medic'. The Tribunal understood Dr Nadal's decision, in light of his retirement and his challenging personal and family circumstances, not to take any practical steps towards remediation. It considered that there was little that could be fairly expected of Dr Nadal at this time in terms of taking steps towards remediation beyond developing insight, which he had begun to do.

61. The Tribunal considered whether Dr Nadal's misconduct was remediable. It was of the view that before Dr Nadal can remediate his inadequate decision-making in respect of Patient B, he must first develop his insight to address the deficiencies identified by the Tribunal. If he were to develop that insight, the Tribunal considered that his misconduct was capable of remediation.

62. In respect of his inappropriate communications, the Tribunal had observed Dr Nadal over a prolonged period of time when he gave oral evidence. It considered that his communication style was, in many respects, likely to be entrenched. However, the Tribunal considered that there was a good foundation for Dr Nadal to remediate concerns about his communications given he has already acknowledged and apologised for the impact of those communication failures on those he was speaking to.

63. In conclusion, the Tribunal considered that, to successfully remediate his misconduct, Dr Nadal 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.

64. If Dr Nadal were, in the future, to seek to return to employment as a registered medical practitioner performing any role, it would be necessary for him to have fully remediated.

Risk of repetition

65. The Tribunal accepted that Dr Nadal had retired and accepted that he genuinely intends to never return to work. However, in considering the risk of repetition, it was required to consider what potential risk there is when insight and remediation are incomplete.

66. In respect of his inadequate decision-making regarding Patient B, the Tribunal determined that there remains a risk. If, in the unlikely event that Dr Nadal found himself in a similar situation in the future, he could repeat his misconduct because he has yet to develop full insight into, and remediate, his failings in decision-making.

67. In respect of Dr Nadal's failures in communication, the Tribunal accepted that he had recognised in his reflective statement that his communications had contributed to the stress of Patient D's relatives. Nonetheless in the absence of remediation of his communication failures, the risk of repetition remained.

Considering the overarching objective

68. The Tribunal then considered whether a finding of impairment was required to uphold the overarching objective.

69. In respect of his inappropriate communications with Ms D, the Tribunal was mindful of the context in which those telephone conversations took place. Dr Nadal had three conversations with Ms D over two days. At times, they ranged in tone and it was clear that emotions were heightened, particularly for Ms D, who was deeply concerned for Patient D, her father.

70. The Tribunal had regard to the positive testimonials provided on Dr Nadal's behalf, many of which in other contexts attested to Dr Nadal's good nature and communication style. The Tribunal also acknowledged Dr Nadal's expressions of remorse at the distress caused. Nonetheless, the Tribunal determined that there was a risk of repetition for the reasons given and that a finding of impairment was necessary to protect patients and uphold the public interest.

71. Moving on to consider Dr Nadal's failings in respect of his decision-making in Patient B's case, the Tribunal was of the view that it was this aspect of Dr Nadal's misconduct that was most serious. Whilst Dr Nadal's decision-making had been found to be deficient in respect of a single policyholder in the context of a career spanning 41 years, the Tribunal determined that 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.

72. The Tribunal determined that, given the severity of Dr Nadal's misconduct, his incomplete insight, lack of remediation, and the paragraphs of GMP that had been breached in respect of Patient B and Patient D, a finding of impairment was necessary to uphold all three limbs of the overarching objective, namely:

- to uphold the overarching objective 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.

73. The Tribunal has therefore determined that Dr Nadal's fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 26/07/2023

1. Having determined that Dr Nadal's fitness to practise is impaired by reason of 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.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

3. No further evidence was adduced at this stage of proceedings.

Submissions

On behalf of the GMC

4. On behalf of the GMC, Ms Kitzing submitted that Dr Nadal's name should be erased from the medical register. Throughout her submissions, Ms Kitzing referred the Tribunal to the Sanctions Guidance (2020) ('the SG'). She referred the Tribunal to its determination on impairment and submitted that it remained relevant for the Tribunal to consider Dr Nadal's incomplete level of insight and remediation. She identified mitigating and aggravating factors for the Tribunal to consider. Ms Kitzing submitted that the aggravating factors outweigh the mitigation identified and stated that the Tribunal is less able to take the mitigating factors into account where the concerns are more serious in nature.

5. Taking the sanctions available to the Tribunal in turn, Ms Kitzing submitted that there were no exceptional circumstances that could warrant no action being taken. In respect of an order of conditions, Ms Kitzing submitted that there were no appropriate or workable conditions that could be imposed to address Dr Nadal's serious misconduct. She further submitted that imposing conditions would not uphold the overarching objective where Dr Nadal is no longer working in a medical capacity and that, though developing, his insight is *'extremely limited'*.

6. Ms Kitzing submitted that suspension would not be a sufficient response to the seriousness of Dr Nadal's case. She submitted that Dr Nadal's misconduct is fundamentally incompatible with continued registration. She submitted that there was no realistic prospect of Dr Nadal gaining full insight or remediating his misconduct given that he has now decided to retire. Whilst she accepted that there was no evidence of repetition since the incidents found proved, Ms Kitzing submitted that this was the only factor that might indicate that suspension could be the appropriate sanction.

7. Ms Kitzing submitted that paragraphs 108 and 109a, b, c, i, and j of the SG were engaged in this case:

> *'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.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> > *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
> >
> > *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)…*
> >
> > *i Putting their own interests before those of their patients (see Good medical practice paragraph 1: – 'Make the care of [your] patients [your] first concern' and paragraphs 77–80 regarding conflicts of interest).*

j Persistent lack of insight into the seriousness of their actions or the consequences.'

8. Ms Kitzing also referred the Tribunal to paragraphs 136 and 137 of the SG, under the heading *'Failure to work collaboratively with colleagues'*:

'136 Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in paragraphs 35–37 of Good medical practice.

137 Colleagues include anyone a doctor works with, whether or not they are also doctors.'

9. Ms Kitzing further submitted that the misconduct in the circumstances of this case was fundamentally incompatible with continued registration where, it was submitted, that there is no realistic prospect of Dr Nadal gaining full insight or remediating his misconduct through appropriate courses, Continuing Professional Development (CPD) or work.

10. Ms Kitzing submitted that the above paragraphs of the SG provided a strong indicator that the appropriate sanction in this case was erasure. She submitted that erasure was the least restrictive sanction that would meet the overarching objective. She therefore invited the Tribunal to direct that Dr Nadal's name be erased from the medical register.

On behalf of Dr Nadal

11. On behalf of Dr Nadal, Mr Geering submitted that the Tribunal must be mindful not to impose a harsher sanction on Dr Nadal on the basis that he had fought the case and therefore lacked complete insight or because he had not undergone a *'Damascene conversion'* and developed insight since the facts determination. Mr Geering reminded the Tribunal that Dr Nadal had a right of appeal which should not be compromised and therefore a harsher sanction should not be imposed for him having not demonstrated complete insight. Nevertheless, Mr Geering conceded that Dr Nadal had not yet developed full insight.

12. Mr Geering accepted that the Tribunal had made serious findings. However, he submitted that such findings were manifestly not compatible with erasure. He submitted that the Tribunal's findings in respect of Patient B and Patient D did not require the ultimate sanction, erasure, to be imposed. Mr Geering accepted that, in the case of Patient B, Dr

Nadal had failed in a number of ways in terms of his judgement and management. However, he submitted that the failings were isolated when considered within the context of Dr Nadal's career as a whole and that the circumstances of Patient B's case had been unusual. Despite being under intense GMC scrutiny since 2015, Mr Geering submitted that the absence of a pattern of misconduct, was relevant.

13. Mr Geering submitted that Dr Nadal's failings did not have a malign motive. He referred the Tribunal to the positive testimonials provided on Dr Nadal's behalf that confirm he is a compassionate man held in high regard. Mr Geering submitted that Dr Nadal has begun to shown a degree of humility. He has accepted shortcomings in his actions and his character. He has begun to reflect on his failings, particularly in respect of his communications with the families of Patient B and Patient D. Further, he has demonstrated a willingness to continue to do so. Dr Nadal's concerns for the impact of his actions on the profession are sincere. Whilst Dr Nadal lacks full insight, Mr Geering submitted that his insight is developing and can develop further. He submitted that Dr Nadal has: shown a degree of insight; has shown respect for the Tribunal's findings; has shown genuine empathy to those affected, namely the families of Patient B and Patient D; he has shown courtesy and respect to his regulator; and has begun to reflect on his misconduct. In such circumstances, he submitted that erasure would be *'grossly'* inappropriate and disproportionate.

14. Mr Geering submitted that a period of suspension was the appropriate and proportionate sanction to impose given the Tribunal's findings. He invited the Tribunal to impose a six month suspension. He submitted that Dr Nadal has retired and this should not be counted against him. Even if Dr Nadal had not retired, Mr Geering submitted that a period of suspension would guard against the risk of repetition identified just as effectively as erasure. Mr Geering submitted that no one could doubt the seriousness of the regulator's response to this case. He submitted that the public interest is proportionate, measured and not intended to be punitive. It would, in Mr Geering's submission, have regard to Dr Nadal's previous good character, the lack of repetition, his constructive engagement with, and respect for, the Tribunal's findings, his demonstration of empathy and his developing insight. Mr Geering submitted that to impose a suspension would respect both the seriousness of the Tribunal's findings and take appropriate account of the mitigating factors that he had identified.

15. Mr Geering referred the Tribunal to Dr Nadal's continued wish to be voluntarily erased from the medical register, and acknowledged that this might not be possible given the Tribunal's findings. He submitted that the length of Dr Nadal's suspension would allow him

time to reflect on the Tribunal's findings and strengthen his insight, having already begun that process. Mr Geering accepted that a review hearing would be directed to ensure the public, and public interests was protected. He acknowledged that a return to unrestricted practice would be contingent on further developed insight, which could be tested and examined by the reviewing tribunal.

The Tribunal's Determination on Sanction

16. The decision as to the appropriate sanction, if any, to impose in this case is a matter for the Tribunal exercising its own judgement. In reaching its decision, the Tribunal has taken the SG into account and borne in mind the overarching objective.

17. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that the purpose of sanctions are not to punish or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Nadal's interests with the public interest.

Aggravating and Mitigating Factors

18. The Tribunal has already set out its decision on the facts and impairment which it took into account during its deliberations on sanction.

19. Before identifying any aggravating or mitigating factors, the Tribunal had regard to its previous findings in respect of Dr Nadal's insight and remediation.

20. The Tribunal accepted that Dr Nadal should not face an enhanced sanction because he had fought the case and may wish to appeal the Tribunal's factual findings. However, the Tribunal had to deal with the evidence before it as to Dr Nadal's level of insight. The Tribunal acknowledged that it was to Dr Nadal's credit that he had demonstrated a willingness to understand the impact of his actions on Patient B, Patient D and their families. It accepted Mr Geering's submission that Dr Nadal's insight is developing. In the Tribunal's judgment, Dr Nadal's development of insight so far, related principally to his communication skills. He has yet to develop insight into his inadequate decision-making that had been found to amount to serious misconduct in respect of Patient B. In particular, Dr Nadal has yet to show insight or appreciation of the duty he had, as a registered medical practitioner in respect of the

decisions he made and which had the potential to impact on the treatment and care received by patients (policyholders).

21. The Tribunal considered that Dr Nadal's developing insight, which was more developed in respect of his communication failings, than his inadequate decision-making, amounted to neither an aggravating, nor a mitigating factor in the circumstances. He had demonstrated how his insight was developing in his written reflections and had shown a willingness to develop that insight further. The Tribunal determined to weigh Dr Nadal's developing insight and its current limitations in the balance as it made its determination on what sanction, if any, to impose.

22. In respect of remediation, the Tribunal reminded itself of its findings and Dr Nadal's current personal circumstances. The Tribunal had found that Dr Nadal's misconduct, regarding his communications and his decision-making, was capable of remediation following the development of further insight. It had also accepted that Dr Nadal had not taken any practical steps towards remediation for genuine and understandable reasons, given his retirement in June 2022, and his challenging personal and family circumstances. The Tribunal, when considering Dr Nadal's application for Voluntary Erasure (VE), was satisfied that his application was made for legitimate reasons and had not been made in an attempt to frustrate the regulatory process by avoiding any finding of impairment or possible sanction. Furthermore, Dr Nadal has evidenced his intention not to return to work by relinquishing his licence to practise before this hearing resumed.

23. The Tribunal considered that it was appropriate for it to consider the information before it today, including its conclusion that Dr Nadal's misconduct would be remediable with the development of further insight, when considering what sanction, if any, to impose. It did not consider that, in the specific circumstances as explained by Dr Nadal, that he should be criticised for failing to take practical steps towards remediation, for example, through attending courses or undertaking CPD, in circumstances when he has decided to retire.

24. Having considered insight and remediation, the Tribunal went on to identify the aggravating and mitigating factors in this case.

25. The Tribunal identified the following aggravating factors:

- Dr Nadal's failings were not isolated, but a series of failings over a number of days in respect of two patients in 2017 and 2018;

- Dr Nadal's unwillingness to move from his own fixed views had resulted in decision-making errors and other failings. In particular, his dogged commitment to his entrenched view that Patient B's best interests lay in Turkey, despite information being available to him that should have led him to question that view. His inadequate decision-making and lack of action until 10 July 2017 had the very real potential to cause grave harm to Patient B. In the Tribunal's view, similar intransigence was evident in Dr Nadal's communications with Ms D;

- In respect of Patient B's case, Dr Nadal had failed to work collaboratively with Dr C, despite Dr C being available to provide him with relevant specialist advice. Dr Nadal could have relied on this advice in circumstances where he should have appreciated he lacked expertise in Patient B's complex, rare and life-threatening condition, and which he had reason to believe was not being adequately treated by the host hospital in Turkey.

26. The Tribunal identified the mitigating factors to be:

- Dr Nadal's expressions of regret and remorse were genuine. He had shown understanding and empathy for the impact of his poor communications on the families of Patient B and Patient D;

- For many years prior to the instant events, Dr Nadal had worked as a registered medical practitioner performing the role of an 'Assistance Medic' without any adverse regulatory findings being made against him. Further, since 2018, Dr Nadal had continued in this field until June 2022 (when he retired) without any repetition of his misconduct;

- There was unchallenged evidence before the Tribunal that at the time of events, the workload of the insurer Dr Nadal worked for had expanded exponentially without a concurrent increase of resource in the Medical Team of which Dr Nadal was the Medical Director. The increased workload of the Medical Team meant that Dr Nadal had less time to devote to cases than he would otherwise have done. The situation with Dr Nadal's principal was particularly relevant to Patient B's case, which occurred in the summer months, the busiest time of the year for 'Assistance

Medics'. However, the Tribunal considered that in his position as Medical Director, Dr Nadal should have been in a position to manage his workload to ensure mistakes of this magnitude were avoided. Accordingly, the Tribunal determined that that whilst these circumstances went some way to explain Dr Nadal's failings, they did not, in any way, excuse them.

- Dr Nadal had been under investigation by the GMC since 2015 and ultimately the Tribunal had found only some of the facts alleged proved and it had found many others not proved. The hearing of the Allegation began in September 2021 and the proceedings have been protracted. There had been a number of lengthy adjournments for reasons beyond Dr Nadal's control, including the matters set out in Annex E. Whilst hearings will likely be stressful for any registrant, the Tribunal acknowledged that the circumstances of this hearing had been particularly stressful to Dr Nadal. From its own observations, the Tribunal concluded that the proceedings had taken its toll on him. The Tribunal considered that it was to Dr Nadal's credit, that in spite of such stressors, he has continued to engage fully with these proceedings and has done his best at all stages to assist and co-operate with the process.

27. The Tribunal had regard to the positive testimonials, mainly from friends and neighbours of Dr Nadal. Whilst the Tribunal was assisted by their assessment of Dr Nadal's character, it considered that they were of limited usefulness in circumstances where Dr Nadal's misconduct took place in a professional setting about which the majority of those providing testimonials did not have relevant knowledge.

28. The Tribunal bore in mind the aggravating and mitigating factors identified throughout its deliberations on what the appropriate and proportionate sanction to impose would be, if any. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

No action

29. The Tribunal first considered whether to conclude the case by taking no action. It accepted that taking no action following a finding of impaired fitness to practise would only be appropriate in exceptional circumstances. It was also mindful that neither party had submitted that it would be appropriate to take no action. The Tribunal determined that there are no exceptional circumstances in this case and that, given the seriousness of its findings, it

would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

30. The Tribunal next considered whether to impose conditions on Dr Nadal's registration. Conditions can be appropriate and workable in certain circumstances, usually where specific shortcomings have been identified in a doctor's practice or support is required for their health. This case relates solely to Dr Nadal's misconduct, and it had not been submitted by either party that conditions was the appropriate sanction. Further, Dr Nadal has retired and relinquished his licence to practise. Therefore, the Tribunal determined that it would be difficult to formulate any appropriate, workable or measurable conditions. Further, it considered that imposing conditions would not be a proportionate response to Dr Nadal's misconduct.

Suspension

31. The Tribunal went on to consider whether to impose a period of suspension on Dr Nadal's registration. The Tribunal accepted that suspension has a deterrent effect and can be used to send a signal to Dr Nadal, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. The Tribunal acknowledged the SG provides that suspension may be appropriate where there is an acknowledgement of fault and it is satisfied that there is not a significant risk of repetition.

32. The Tribunal considered paragraphs 92 and 97a, e, f, and g of the SG to be particularly relevant to its consideration of suspension:

> *'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).*
>
> *97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.*

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors…

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'

33. In considering whether Dr Nadal's misconduct was fundamentally incompatible with continued registration, the Tribunal considered the serious breaches of GMP it had identified. The Tribunal balanced Dr Nadal's failings and breaches of GMP against the mitigating factors in this case, and bore in mind that Dr Nadal was developing insight into his misconduct and was committed to reflecting further on his actions and their impact. There was no evidence before the Tribunal that Dr Nadal was unwilling or unable to develop further insight into his misconduct.

34. The Tribunal was satisfied that with appropriate insight, Dr Nadal could appropriately remediate his misconduct. There was no evidence that Dr Nadal had repeated his misconduct prior to his retirement in June 2022. Further, in the unlikely event that Dr Nadal did, in the future, wish to return to practice, the Tribunal was satisfied that these proceedings had had an impact on Dr Nadal and whilst there was a risk of repetition due to the lack of complete insight and remediation, that risk was not *significant*. Further, any risk of repetition would be reduced with the development of appropriate insight and remediation (if Dr Nadal were to seek to return to medicine).

35. In all the circumstances, the Tribunal concluded that Dr Nadal's misconduct was not fundamentally incompatible with continued registration such as to require erasure. However,

that was not to detract from the seriousness with which it viewed that misconduct and the importance of marking that seriousness and upholding the overarching objective.

36. The 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.

37. It had been submitted by the GMC that erasure was the only appropriate and proportionate sanction in this case. The Tribunal had regard to the relevant paragraphs of the SG that relate to erasure, including those set out above (paragraph 108 and 109a, b, c, i and j). The Tribunal had already determined that Dr Nadal's misconduct was not fundamentally incompatible with continued registration, however, it accepted that it was appropriate to consider whether any other indicators for erasure were present.

38. The Tribunal had not found that Dr Nadal's actions, serious as they were, amounted to a deliberate or reckless disregard of either the principles set out in GMP, or his duties as a registered medical practitioner. It had not been alleged or found, that Dr Nadal's actions had caused or contributed to the death of Patient B. The Tribunal had found that the proven failings relating to Dr Nadal's inadequate decision-making had potentially deprived Patient B of an opportunity to receive expeditious and effective treatment that might have resulted in a different outcome for him.

39. Nevertheless, in the Tribunal's judgment, Dr Nadal's failings in respect of Patient B involved a high degree of culpability, as set out in previous determinations. Dr Nadal's decision-making was inadequate because he failed to monitor Patient B, he failed to discuss Patient B's case with Dr C who was offering relevant specialist advice and he failed to consider the need for early aeromedical repatriation in circumstances where he knew, or ought to have known, that Patient B had a complex, rare and life-threatening condition requiring specialist care that he was not receiving at the host hospital.

40. The Tribunal did not consider that Dr Nadal's failings could be accurately characterised as him putting his own interests before those of Patient B, Patient D and/or their families. Rather, Dr Nadal had believed that his primary duty was to his principal, the insurer, but that was not to say he put his own interests ahead of those of any patient within the meaning of paragraph 109i of the SG.

41. 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 on 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.

42. In the particular circumstances of this case, it was accurate to describe Dr Nadal's misconduct as two separate episodes, the most serious of which related to Dr Nadal's multi-faceted decision-making failures in respect of Patient B, in an otherwise lengthy career. There was evidence of developing insight and the Tribunal had found that Dr Nadal's failings were capable of remediation once further insight has developed. The Tribunal had regard to the significant impact that these proceedings had had on Dr Nadal.

43. The Tribunal considered that it was right that, in circumstances where it has identified that Dr Nadal has capacity to develop further insight and remediate, that he be given the opportunity to do so. The Tribunal was also mindful that Dr Nadal will be ending his career with a sanction, which would inevitably have an impact on him. In the Tribunal's judgment, this would go some way to upholding the overarching objective, namely by promoting and maintaining public confidence in the medical profession and promoting and maintaining proper professional standards and conduct for members of the profession.

44. In these circumstances, the Tribunal determined that to erase Dr Nadal's name from the medical register would be disproportionate and unnecessarily punitive.

45. Having considered the sanctions in ascending order of restrictiveness and having determined to suspend Dr Nadal's registration, the Tribunal went to on to consider the length of the period of suspension for him. The Tribunal determined to suspend Dr Nadal's registration from the medical register for a period of 12 months. Whilst the Tribunal had determined that Dr Nadal's misconduct was not fundamentally incompatible with continued registration, its findings were serious. 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.

46. 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.

47. 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.

Determination on Immediate Order - 26/07/2023

1. Having determined to suspend Dr Nadal's registration, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Kitzing submitted that an immediate order was not necessary.

3. On behalf of Dr Nadal, Mr Geering agreed that an immediate order was not required.

The Tribunal's Determination

4. The Tribunal had regard to paragraphs 172 to 178 of the SG. It took account of the guidance, the submissions of both parties and the specific basis upon which the Tribunal reached its determination on sanction.

> *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…*

5. The Tribunal determined that the substantive order upholds the overarching objective in maintaining public confidence in the profession and maintaining proper professional

standards. It determined that an immediate order was not necessary to protect members of the public as Dr Nadal has retired and relinquished his licence to practise.

6. The Tribunal therefore determined not to impose an immediate order of suspension on Dr Nadal's registration.

7. This means that Dr Nadal's registration will be suspended 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Nadal does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

8. There is no interim order to revoke.

9. That concludes the case.

ANNEX A – 23/09/2021
Application to admit further evidence

1. Ms Kitzing, on behalf of the GMC, made an application, pursuant to Rule 34, for the evidence of Dr I, a consultant cardiologist, to be admitted. The statement of Dr I, dated 12 September 2021, related to his opinion as to whether, at the relevant time, there would have been a significant delay in Patient D being considered for investigation by angiography and referral for appropriate investigation if he had been repatriated to the UK.

2. By way of background, in March 2019, Dr H, Patient D's GP, wrote to Patient D's family detailing his involvement in Patient D's care. Within that letter he referred to his communication with a consultant colleague [Dr I] who had given his opinion as to the anticipated waiting times for angiography in the UK.

3. In due course, the letter sent by Dr H was exhibited to a statement of one of the members of Patient D's family and was included within the draft hearing bundle that the GMC served on Dr Nadal's legal representatives for agreement on 10 May 2021.

4. On 2 August 2021 Dr Nadal's legal representatives objected to the inclusion of Dr H's letter in the bundle. Objection was taken on the grounds that the letter amounted to 'double hearsay' from an anonymous source.

5. Accordingly, the GMC notified Dr Nadal's legal representatives that they would be seeking a witness statement from Dr H. For reasons that it is unnecessary to detail, there was some delay in obtaining a signed witness statement from Dr H and it was not served on Dr Nadal's legal representatives until the 7 September 2021. Shortly, thereafter the GMC obtained the statement from Dr I which is the subject of the application.

Submissions

6. Ms Kitzing submitted that the GMC now wished to rely upon the evidence of Dr I in substitution for the evidence of Dr H. Ms Kitzing submitted that this evidence is both relevant and fair and that it would further the overarching objective for it to be admitted before the Tribunal.

7. With regard to relevance, Ms Kitzing submitted that the evidence was relevant to the allegation at paragraph 6(a)(iv), 6(d)(ii) and, to a lesser extent, paragraph 7(f) of the Allegation.

8. In relation to paragraphs 6(a)(iv) and 6(d)(ii), Ms Kitzing submitted that, given Dr I's opinion, that the anticipated waiting time for angiography/catheterisation in the UK would have been less than the 1 month anticipated waiting time in Gran Canaria. This would support the allegation that Dr Nadal had failed to have '*sufficient regard*' to the need to wait at least a month for the same procedure '*locally*'. It was submitted it would also support the allegation that Dr Nadal should have sought advice from a UK cardiologist [as to the anticipated waiting time in the UK]. Further, Ms Kitzing submitted that, the shorter the anticipated waiting time in the UK, the greater the regard, or weight, Dr Nadal should have attached to the fact that the waiting time in the Canaries would be at least a month.

9. With regard to paragraph 7(f), Ms Kitzing submitted that, if the waiting time in the UK would have been less than that expected in the Canaries, this evidence would cast doubt upon the '*veracity*' of Dr Nadal's statement that '*delays for cardiac intervention in the UK were the worst in Europe'.*

10. As to fairness, Ms Kitzing, whilst acknowledging the delay in serving Dr I's statement, submitted that the content should not have come as any surprise to Dr Nadal's legal representatives given that its contents were foreshadowed in Dr H's letter and, subsequently, his statement.

11. On behalf of Dr Nadal, Mr Edis conceded that the evidence had some relevance to the issue at paragraph 6(a)(iv) but not otherwise. However, he submitted that it would be unfair for the evidence to be admitted given the lateness of service of the same i.e. a week after the hearing had begun.

12. Mr Edis was strident in his criticism of the GMC and submitted that the GMC were responsible for culpable delay in obtaining the statement from Dr I. He submitted that it should have been obvious at a very early stage that the evidence on which the GMC initially sought to rely was inadmissible as it amounted to 'double hearsay' from an anonymous source. Further, it should have been obvious that a statement from Dr I was required as opposed to a statement from Dr H whose evidence on the relevant issue was itself hearsay.

13. Mr Edis submitted that not only was the GMC at fault in not serving the evidence of Dr I sooner, but, more importantly, there would be unfairness to Dr Nadal if it was admitted. He highlighted that Dr I's opinion expressed in March 2019 with regard to waiting times in March 2018 did not go beyond mere assertion. As a consequence, it was submitted, Dr Nadal

would be prejudiced by his inability, at this late stage, to meet, or challenge, Dr I's evidence either by way of cross examination or by obtaining his own evidence in rebuttal.

The Tribunal's decision

14. The Tribunal first considered the issue of the relevance of Dr I's evidence. With regard to paragraph 6(a)(iv) and 6(d)(ii), the Tribunal did not consider that the evidence was directly relevant in the sense that it was evidence necessary in order to prove an essential element of the allegations. However, the Tribunal acknowledged that evidence as to the actual period of time that Patient D might have had to wait for cardiac catheterisation in the UK would have some relevance to the degree of regard Dr Nadal should have had to this factor when the anticipated waiting time in the Canaries was likely to be at least 1 month and as to whether Dr Nadal should have therefore sought advice from a UK cardiologist.

15. Despite the fact that the Tribunal considered the evidence of Dr I to have some relevance, it took the view that even if the Tribunal accepted the evidence, the weight it could attach to it would be limited. The Tribunal noted that Dr I had not been asked to consider, or make enquiries, as to the issue at the time of the relevant events. He was asked more than a year after the events as a UK cardiologist who worked in the local health area to which Patient D was repatriated in March 2018. Furthermore, Dr I had been asked to opine as to what he would have expected with regard to waiting times with a limited patient history and without being fully informed of all the relevant circumstances relating to Patient D's situation as at March 2018.

16. The Tribunal did not consider that Dr I's evidence had any relevance to the allegation at paragraph 7(f).

17. Firstly, the allegation at paragraph 7(f) is that Dr Nadal's comments with regard to delays for cardiac intervention in the UK were '*innappropriate'* and <u>not</u> that they were untrue and, much less, is it an allegation that Dr Nadal knew that the statement was untrue. Therefore, the issue is not whether the statement was true or whether Dr Nadal believed it to be true, rather the issue is whether it was 'appropriate' for Dr Nadal to make the statement to a member of Patient D's family in the circumstances in which it was made.

18. Secondly, the Tribunal determined that, even if the truth or otherwise of Dr Nadal's statement was in issue, Dr I's opinion as to the likely waiting time in respect of one patient for a particular cardiac investigation in a specific health area in the UK would, even if

accepted, be an insufficient basis for the Tribunal to conclude that Dr Nadal's statement with regard to delays for cardiac intervention in the UK generally was untrue.

19. The Tribunal next considered the fairness in admitting Dr I's evidence.

20. The Tribunal carefully considered the chronology of events leading to the late service of Dr I's witness statement. The Tribunal did not accept much of the strident criticism of the GMC with regard to the delay. However, it did conclude that the GMC should have appreciated the need to obtain a witness statement from Dr I sooner if they wished to rely upon his opinion evidence. Further, the Tribunal accepted that Dr Nadal did not bear any responsibility for the delay.

21. Further, the Tribunal considered that although Dr I was being presented as a witness of fact, his evidence was, to all intents and purposes, that of an expert. Dr I had not at anytime had any involvement in the treatment or care of Patient D. His involvement in the case was limited to his being asked a year after the relevant events as to his opinion, as a Consultant Cardiologist working within Patient D's local health area, as to the state of waiting times for cardiac investigations.

22. In these circumstances the Tribunal determined that there was a real potential for prejudice to Dr Nadal if the opinion evidence of Dr I were to be admitted because he would be deprived of the opportunity for either Dr I to be effectively cross examined on his behalf or to obtain his own expert evidence in rebuttal, without an adjournment, to obtain the same.

23. Therefore the Tribunal concluded that it would not be fair to admit the evidence of Dr I and refused the GMC's application.

ANNEX B – 15/10/2021
Adjournment and Tribunal directions

1. This hearing was scheduled to conclude on 15 October 2021. There is insufficient time remaining to conclude the case.

2. This hearing will now adjourn part-heard, subject to Rule 29(2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to 4 July 2022 to 27 July 2022 and 14 September 2022 to 23 September 2022.

Tribunal Directions

3. Having regard to its powers under Rule 16(1), 16(1A) and 16(6) of the Rules, the Tribunal made the following directions:

a) by 15 December 2021, the GMC are to serve on Dr Nadal's legal representatives any further evidence upon which they seek to rely together with any skeleton argument in support of an application for permission to admit such evidence.

b) by 31 January 2022, Dr Nadal's legal representatives to serve on the GMC:

i) any skeleton argument in opposition to any application by the GMC for permission to admit further evidence.
ii) any skeleton argument in support of an application for further particulars as to the meaning to be attributed to the word 'inappropriate' and 'unprofessional' as they appear in the notice of Allegation.
iii) any skeleton argument in support of an application to stay the proceedings as an abuse of process.

c) by 31 January 2022, Dr Nadal's legal representatives to serve any further evidence upon which they propose to rely.

d) by 7 March 2022, GMC to serve a reply to any skeleton argument served pursuant to the direction at paragraphs b(ii) and b(iii) and any skeleton argument in opposition to the admission of any further evidence served pursuant to paragraph (c).

The Tribunal further directed

4. The case should be listed for a Case Management hearing on 6 June 2022 (or such other date as may be directed) before the Legally Qualified Chair, or other Case Manager, in order to consider case management issues only and to make such further directions as to future case management as may be required.

5. Further, at the Case Management hearing as provided for under paragraph 4, the GMC shall confirm that any audio recordings that are to played at the resumed hearing have been suitably redacted.

6. The case was adjourned part heard.

ANNEX C – 19/07/2022
Application under Rule 17(2)(g)

1. At the close of the GMC's case, Mr Edis QC made an application under Rule 17(2)(g) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules') that there was no case to answer in respect of paragraphs 1-7 of the Allegation.

Relevant Background

2. Dr Nadal qualified 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 remains the director. Lifeline provides an advisory service to travel insurance companies who insure travellers from the United Kingdom (UK). Dr Nadal has considerable experience within the repatriation and travel insurance industry. Dr Nadal whose role is described as an 'Assistance Medic' and is employed/engaged by insurance companies to advise as to whether an insured person is covered for medical treatment under the terms of their travel insurance policy. In particular, in the context of this case, he also provides advice to the insurance company as to whether an insured who has become unwell abroad should be repatriated home by air ambulance for treatment and care.

3. Since 2011, Dr Nadal has been the Medical Director of Travel Insurance Facilities' ('TIF') assistance service, Emergency Assistance Facilities ('EAF'). Dr Nadal is not employed by TIF but engaged through his company, Lifeline. The Medical Team, which Dr Nadal leads, advises TIF on medical matters relating to insured UK travellers, specifically on if, when and how to transfer people who have become unwell abroad. It is important to record that TIF,

EAF, Lifeline, and by extension Dr Nadal, do not advise or take responsibility for decisions on, or the provision of, treatment to the insured. This responsibility remains with the medical professionals who are, at the relevant time, providing treatment and care to the insured as their patient. Those will usually be, and were in these cases, the doctors who were treating the insured at a hospital in the host country.

4. The Allegation against Dr Nadal relates to three travel insurance policyholders in respect of whom repatriation was sought under the terms of their policies following their 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 does not relate to any alleged failures by Dr Nadal in any supervisory capacity. Rather, the Allegation relates 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 A and 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 do not allege that the insurers refusal to repatriate Patient A, Patient B or Patient D on the advice of Dr Nadal, caused or contributed to their deaths. Neither is it alleged that the decision not to repatriate was necessarily the wrong decision in the circumstances.

6. However, it is alleged that, in relation to all three patients, the decisions not to repatriate were inadequate due to a number of failures in the obtaining and/or ascertaining of relevant information in order for an informed and adequate assessment of the relative risks and/or benefits as between repatriation to the UK or the patients remaining in the host country for treatment. It is alleged that the relevant information was either not sought at all, or was not sought when it ought to have been. Further, it is alleged in relation to communications between Dr Nadal and the families of both Patient B and Patient D, and Ms E, a Consular Officer involved in Patient D's case, that Dr Nadal's communications were on occasions inappropriate and unprofessional.

7. Mr Edis's application relates to all of the above paragraphs of the Allegation, save for paragraph 8 which relates to Dr Nadal's communications with Ms E.

<u>Patient A</u>

8. The Tribunal was provided with witness statements from Ms A (Patient A's wife), Mr AA (Patient A's son), Mr A (Patient A's son) and Dr J, who treated Patient A at the Myung Sung Medical Centre in Addis Ababa, Ethiopia. It also heard oral evidence from Ms A, Mr BA and Dr J. The Tribunal received documentary evidence, including the EAF event log, call transcripts and excerpts of clinical records relating to Patient A's treatment.

9. On 11 March 2016, Patient A was found unconscious in his hotel room. He appeared to have fallen and hit his head. Patient A was initially taken to the Nordic Medical Centre where he was under the care of Dr V and underwent a CT scan. The CT scan identified a subdural haematoma. Clinicians concluded that Patient A required an operation to evacuate the haematoma and to relieve pressure on his brain. Patient A was transferred to the Myung Sung Medical Centre and neurosurgery was performed by Dr J. EAF had been informed of Patient A's admission to hospital for surgery on the same day.

10. Following the surgery, Dr J informed Ms A that the operation had been a success, there was no physical trauma to the brain and the brain was pulsating normally. Post-surgery Patient A was admitted to the Intensive Care Unit (ICU) where he remained ventilated and under sedation.

11. On 12 March 2016, Patient A was found to have an elevated white cell count. It was considered that this could have been a sign of infection or an inflammatory response following the surgery. By 16 March 2016 Patient A was diagnosed as having sepsis.

12. On 13 March 2016, Dr F, a member of EAF's Medical Team with conduct of Patient A's case, spoke with Dr J. Dr F also spoke with Ms A and sent her an email confirming what milestones would need to be achieved before Patient A could be safely repatriated back to the UK.

13. On 16 March 2016, Dr F spoke with Dr J again. It was confirmed that Patient A had shown no improvement clinically. Dr F did not consider that Patient A was at that time sufficiently fit for air repatriation. However, as Patient A's family were keen for Patient A to be repatriated and said they had been advised that Patient A should be repatriated, Dr F requested that Dr Nadal review the case. On the same day, Dr Nadal subsequently spoke to Mr BA. This was his first, and only direct involvement in Patient A's case. Dr Nadal confirmed the view of Dr F to Mr BA that Patient A was not, at that time, fit for repatriation.

14. On 18 March 2016, while Patient A's family had been seeking to organise his repatriation back to the UK themselves, Patient A died. Post-operatively, Patient A had developed persistent high blood pressure and sepsis, his immediate cause of death was cardiac arrest.

15. The Tribunal was provided with expert evidence from Dr P, a Consultant Anaesthetist and aeromedical retrieval specialist trained in the Royal Air Force (RAF). She provided expert reports and gave oral evidence at the hearing.

Patient B

16. The Tribunal was provided with witness statements and heard oral evidence from Ms BB (Patient B's wife), Ms B (Patient B's mother) and Dr C (Patient B's treating consultant haematologist). It was also provided with various email correspondence between Patient B's family, Dr C and EAF, as well as an event log from EAF, transcripts and recordings of telephone calls between Dr Nadal and Ms BB and an extract of Patient B's medical records.

17. Patient B suffered from Evan's Syndrome, an autoimmune disease resulting in haemolytic anaemia and thrombocytopenia (low platelet count) and was under the care of a consultant haematologist (Dr C) based at Worthing Hospital. Relapses of this condition were treated with blood transfusions, steroids and other immuno-suppressants. For a number of years Patient B's condition had been well-managed. On 15 June 2017, with his consultant Dr C's approval, Patient B and his family, including Ms BB and Ms B, travelled to Turkey for a holiday.

18. On 28 June 2017, Patient B became unwell. He commenced a course of steroids that had been prescribed by Dr C in case of a relapse whilst he was abroad. Ms B spoke directly to Dr C seeking further advice about Patient B. The following morning, on 29 June 2017, Patient B deteriorated further. He was transferred by ambulance to Yucelen Hospital, Ortacha (a private medical facility). Later that same day, Patient B was transferred to Yucelen Hospital Mugla (another private hospital) which was considered by the doctors at the Yucelen Hospital, Ortacha, to have better facilities. He was admitted under the care of a cardiologist. The hospital did not have a haematologist on site. Ms B remained in Turkey with Patient B, while the rest of the family travelled home on their scheduled flight. EAF were informed of Patient B's admission to hospital on 30 June 2017.

19. On 1 July 2017, an EAF team member emailed Ms BB and requested her assistance in obtaining a medical report from the treating hospital. Ms B stated that she had been informed by the treating clinicians that there was no suitably qualified doctor to deal with Patient B's condition at the hospital and that an air ambulance was required.

20. On 2 July 2017, EAF were in email and telephone communication with Ms B and Ms BB. Grave concerns were being expressed by them to EAF that Patient B was not receiving the treatment he required and that the treating clinicians had not recognised the fact that his condition was deteriorating. EAF requested Ms B/Ms BB's assistance in obtaining a medical report and also emailed the hospital requesting a medical report *'urgently for our medical team to review in order to ensure that* [Patient B] *is receiving the medical treatment that he urgently needs'*.

21. It is alleged that on 3 or 4 July 2017 [the date in this respect is immaterial], an email was received by EAF with an attached medical report in Turkish. The email received from the Mugla Yucelen Hospital stated *'GETTING TREATMENT AT MUGLA YUCELEN HOSPITAL AND NEED AIR AMBULANCE TRANSPORTATION HIS SITUATION SERIOUS'*. The body of the email further stated that Patient B was a *'serious hemolitic anemic patient* [sic]*'*, that his body was not responding to treatment, and to *'Please arrange for him air ambulance transportation'*.

22. Thereafter, the EAF event log records involvement of members of the Medical Team, including Dr Nadal, in relation to Patient B's family seeking to secure the repatriation of Patient B to the UK and EAF's declining to do so and which is the subject matter of paragraphs 2, 3 and 4 of the Allegation. Paragraph 4 of the Allegation related to a conversation on 10 July 2017 between Dr Nadal and Ms BB in which it is alleged was inappropriate in a number of respects. It was during that conversation that Dr Nadal gave an indication that an air ambulance would be arranged by EAF for the purposes of repatriation. However, as a result of a further deterioration in Patient B's condition, he died on 12 July 2017 before any air ambulance transportation had been arranged.

23. The Tribunal received expert evidence, both written and oral, from Dr Q, a consultant in Anaesthesia and Intensive Care Medicine. Dr Q's commenced his anaesthetic training with the RAF and having left the RAF in 1990, he continued to work for aeromedical companies on an ad hoc basis in a private capacity.

Patient D

24. The Tribunal received witness statements from Ms D (daughter of Patient D) and Ms DD (daughter of Patient D). Both also gave oral evidence. The Tribunal also received a copy of Ms E's records (a British Consular Official in Lanzarote who became involved in Patient D's case following contact from Ms DD) along with recordings and transcripts of telephone calls, and various communications between EAF/Dr Nadal and members of Patient D's family and a treating clinician.

25. On 6 February 2018, Patient D travelled to Lanzarote with Ms D and her family. On 11 February 2018, Patient D became unwell, he was breathless, irritable and pale. Patient D was taken by taxi to a hospital by Ms D. He had an ECG and was transferred by ambulance to Hospital Doctor José Molina Oros ('the Hospital'). Ms D was informed that Patient D had had at least one heart attack by the time she arrived at the Hospital, but had potentially already had three heart attacks and that he was seriously ill.

26. On 12 February 2018, Patient D was admitted to the Intensive Care Unit. Ms D was told by Patient D's treating doctor that the Hospital did not have the facilities for exploratory surgery or cardiac intervention. Ms D spoke with EAF about obtaining a medical report from the Hospital and signed consent so that Patient D's details could be obtained from his GP.

27. On 13 February 2018, the EAF event log confirmed that Patient D had suffered a STEMI (ST-Elevation Myocardial Infarction) with a background of chronic cardiac disease. It was noted that Patient D would most likely require transfer to Gran Canaria for further investigations and treatment.

28. On 19 February 2018, EAF called the Hospital to chase the previously requested medical report and was told to call back. Ms D had flown home on 17 February 2018, Ms DD then flew out to be with Patient D. On 20 February 2018, communication with the treating hospital confirmed the diagnosis of myocardial infarction with 40% dysfunction of the heart. Patient D also had a chest infection. The treating doctor suggested that Patient D would need operative intervention in Gran Canaria which it was estimated he would have to wait for one month. The treating doctor suggested repatriation via air ambulance to the UK.

29. On 21 February 2018, EAF received two pages of a medical report and sought to obtain a copy of the complete report. On 23 February 2018, EAF received the full report. The treating doctor suggested Patient D be repatriated to the UK. Dr G, a member of the EAF

Medical Team, who had been dealing with the matter up to that time discussed the case with Dr Nadal. They both agreed that Patient D should continue to be treated locally and repatriated when it was safe to do so. If the Hospital did not have the appropriate facilities, they agreed that Patient D would need to be transferred to Gran Canaria. Dr G called Ms D to explain that repatriation was not an option given what was being suggested to her to be the high risk involved in repatriation by air.

30. On 26 February 2018, EAF telephoned the Hospital to explain that Patient D was not fit for UK repatriation and should be transferred to Gran Canaria for further treatment. The Hospital staff member told EAF there was a waiting list for cardiac catheterisation in Gran Canaria.

31. On 28 February 2018, Ms D spoke to Dr Nadal two times. This was the first direct communication Dr Nadal had with Patient D's family. On the same day, a member of the Consular staff called EAF to ask if Patient D could be treated privately as his condition had deteriorated and that the state hospital in Gran Canaria had a waiting list of one month.

32. On 1 March 2018, Ms D spoke to EAF to request private medical care. EAF informed her that private care would have to be authorised by the Medical Team. Dr Nadal spoke with Ms D later that same day.

33. On 5 March 2018, Dr Nadal, having seen a further medical report, made contact with a nurse at the Hospital who reiterated that the wait time for a transfer would be about a month. EAF told Ms D that a delay arising from Patient D's initial lack of an EHIC card had been resolved and he had then been placed on the active waiting list for cardiac catheterisation at the public hospital in Gran Canaria.

34. On 6 March 2018, Dr Nadal spoke to Patient D's treating cardiologist, who confirmed that cardiac intervention could still be one or two weeks more. Dr Nadal said that the family should be given telephone numbers of air ambulance companies so they could arrange their own repatriation.

35. On 7 March 2018, EAF told Patient D's family that the wait for angiography had shortened to one to two weeks and that Patient D was currently stable. EAF advised that it was safer to wait for local treatment than to fly Patient D back to the UK but if the family wanted to organise an air ambulance, EAF would offer a contribution to the costs.

36. On 8 March 2018, Patient D's GP Surgery contacted EAF to say they were keen for Patient D's treatment to be expedited or his family to be given a full explanation as to why that would not be possible. Ms D received an email from EAF setting out why Patient D should not be repatriated despite his treating clinicians considering him fit to fly and set out relevant information about other options. Ms D was told she was free to approach air ambulance companies herself and some costs would be reimbursed by EAF.

37. On 14 March 2018, there was further communication between Patient D's family and EAF.

38. On 15 March 2018, EAF contacted Ms D with a list of air ambulance services they used.

39. On 21 March 2018, Ms D emailed to confirm that an air ambulance had been booked for Patient D for 23 March 2018.

40. Patient D was repatriated back to the UK on 24 March 2018.

41. On 26 March 2018, EAF were informed that Patient D had had a stroke.

42. On 28 March 2018, Patient D passed away.

43. The Tribunal received expert evidence, both written and oral, from Dr Q who had also reported on Patient B.

Submissions

Submissions on behalf of Dr Nadal

44. Mr Edis provided the Tribunal with extensive and detailed written argument, together with some transcript excerpts of the evidence. For the sake of brevity, it is unnecessary to repeat the submissions set out in Mr Edis's skeleton arguments in detail. In summary, the Tribunal understood the submissions to be as follows:

(1) No established duty

45. Mr Edis submitted that the GMC had failed to establish that Dr Nadal was under a duty to do that which it was alleged he had failed to do, i.e. failed to adequately assess whether air evacuation was required, (relevant to paragraphs 1, 2, 3, 5, and 6 of the Allegation) or that he was under a duty not to do that which it is alleged he did, i.e. communicated inappropriately/unprofessionally with family members of Patient B and Patient D (relevant to paragraphs 4 and 7 of the Allegation). Further, that if he was under any duty as alleged, the GMC had failed to identify the nature or extent of that duty.

46. Mr Edis's submission was based upon the fact that Dr Nadal could not have been regarded as being in a doctor/patient relationship with Patient A, Patient B or Patient D. Rather, he was acting in the capacity of an 'Assistance Medic', an individual who is employed/engaged by insurance companies to advise their principal, namely the insurance company, as to whether the insured is covered under the terms of their policy and whether it is necessary for them to be repatriated for medical treatment. In these circumstances, it was submitted, there is no therapeutic relationship or traditional doctor/patient relationship, neither is there any contractual relationship with the 'patient'. It was submitted therefore that any duty that Dr Nadal owed was a duty which was owed solely to the insurer.

47. Mr Edis highlighted the fact that the role of an 'Assistance Medic' is common within the travel insurance industry and that it is a role that can be performed by anyone and does not require the individual to be a registered medical practitioner: the person doing the job is not responsible for, or engaged in, the treatment of the insured; such enquiries as they may see fit to make are designed to enable them to discharge their duty to the company that engage their services; the interests of the company and the interests of the insured may conflict, and, in any event, it is the insurer that is the decision-maker and the 'Assistance Medic' works solely in an advisory capacity.

48. Mr Edis further submitted with regard to the paragraphs of the Allegation concerning Dr Nadal's alleged inappropriate communications with members of Patient B and Patient D's families, that his duty was limited to a duty of honesty and candour. Given that the GMC did not allege that anything Dr Nadal had said to members of Patient B and Patient D's families was untrue, or at least it was not alleged, that he did not believe them to be untrue, Mr Edis submitted that the paragraphs of the Allegation relating to inappropriate/unprofessional communications could not be sustained.

(2) No *'admissible'* evidence as to duty, standard or breach of duty

49. Further, and/or in the alternative, Mr Edis submitted that if Dr Nadal was under a duty, the GMC had provided no *'admissible'* evidence which identified the nature or extent of the duty or, more specifically, the standard against which the acts or omissions of an 'Assistance Medic' should be judged.

50. Mr Edis submitted that such evidence could only be furnished by an expert with the necessary knowledge and experience to opine upon the role of an 'Assistance Medic'. Mr Edis asserted that such expert evidence was readily available but the GMC had not sought to obtain it. Rather, the GMC had instructed clinicians who were Consultant Anaesthetists, experts in air repatriation, but neither of whom had any qualification, knowledge or experience in the field of 'assistance medicine' in the insurance industry context. He submitted that the standard against which the experts had judged Dr Nadal's actions was set too high and was not a standard that he could reasonably be expected to have met. Dr Nadal was neither a clinician, nor was he was a Consultant, therefore he should not have been judged, it was submitted, by the standards of the same. Mr Edis submitted that the expert evidence on what had been identified as Dr Nadal's duties was *'transparently inadmissible and should carry literally no weight'*.

51. In these circumstances, Mr Edis criticised the experts to the extent of submitting that neither of them should ever have accepted instructions to comment upon Dr Nadal's performance. He made further numerous and strident criticisms of the experts referring to the codes of conduct that bind expert witnesses, submitting that there had been wide-ranging breaches. For example, the experts had strayed outside their area of expertise; they had shown partiality and bias; and had demonstrated *'a lazy and slapdash attitude'*.

52. With regard to the paragraphs of the Allegation concerning inappropriate/unprofessional communications, Mr Edis submitted that it was questionable whether expert evidence was *'admissible'* or helpful on questions of communication at all. He submitted that this was particularly true if the expert giving evidence has no experience of the context in which the conversations occurred, i.e. a non-therapeutic but *'explicatory'* conversation, they had never worked in an insurance environment, and they had never had such conversations.

53. It necessarily followed from Mr Edis's submissions that, if there was no *'admissible'* evidence to identify the duty or the standard against which Dr Nadal's acts or omissions

should be judged that there would similarly be no *'admissible'* evidence of the breach of any duty by him and which would be necessary to prove paragraphs 1-7 of the Allegation.

(3) Insufficiency of evidence of fact in relation to specific allegations

54. In addition to Mr Edis's overarching submissions regarding the existence of a duty, the standard against which Dr Nadal's actions should be measured and/or the breach of any such duty, Mr Edis submitted that in relation to a number of specific paragraphs of the Allegation that there was insufficient evidence of primary fact to support the same.

Submissions on behalf of the GMC

55. On behalf of the GMC, Ms Kitzing submitted that there was a case to answer in respect of all paragraphs of the Allegation. Ms Kitzing provided a detailed skeleton argument in addition to her oral submissions.

56. In summary, Ms Kitzing submitted that at all material times, Dr Nadal was a registered medical practitioner with a licence to practise and in this respect he was under a duty to comply with Good Medical Practice (2013) (GMP), even in the field of practice in which he was operating, namely 'assistance medicine'. Further, he was working as the Medical Director for EAF, part of TIF, an insurance company, where decisions were being made about the care of patients and their potential repatriation. Ms Kitzing submitted that these facts were important to this case because Dr Nadal introduced himself as 'Dr Nadal' and 'Medical Director' on all calls with the patients' families and other medical professionals; he discussed patients' medical issues, treatment and care; he utilised his medical knowledge regarding the patients' cases in advising the insurance company regarding repatriation; he led a team of medical practitioners and nurses; and he had overall responsibility for making the final decisions on individual patient cases.

57. Regarding the expert evidence, Ms Kitzing submitted that both experts provided opinions on Dr Nadal's decisions regarding repatriation, which were clearly within both experts' expertise. Ms Kitzing conceded that neither of the GMC experts had gained their expertise within the setting of a commercial enterprise, such as an insurance company, neither had they experience or knowledge of 'assistance medicine' and she acknowledged that there were differences between clinicians performing repatriations and the role that Dr Nadal was performing. However, the expert opinions of Dr P and Dr Q were sought as retrieval experts, experts in making medical decisions as to repatriation, which is wholly

pertinent to the decisions faced by Dr Nadal in his role as Medical Director at EAF and the Allegation before the Tribunal. Accordingly, she submitted that the experts had sufficient expertise to opine upon the role Dr Nadal performed. She submitted that where both experts had considered the standards expected of a reasonably competent consultant (Dr P) or (registered) medical practitioner (Dr Q), their opinions were admissible as to the standard of conduct to be reasonably expected of Dr Nadal in performance of his role as a *registered medical practitione*r performing the role of 'Assistance Medic'.

58. Ms Kitzing submitted that Dr P, at one stage, having considered Dr Nadal's conduct against the standard of a reasonably competent 'Consultant Anaesthetist', which title was taken from an incorrect Curriculum Vitae (CV) that had been provided on behalf of Dr Nadal. As a consequence, incorrect instructions had been given by the GMC to Dr P. Ms Kitzing stated that it would be unfair to criticise Dr P for this error. She submitted that Dr Nadal had been judged by both experts as being experienced in his field of medicine. Ms Kitzing submitted that if the Tribunal accepted that Dr P and Dr Q had relevant expertise, the breaches they set out in terms of Dr Nadal's decisions not to repatriate the patients were clearly made out.

59. On communications, Ms Kitzing submitted that the *'judgment words'* contained in paragraphs 4 and 7 of the Allegation, e.g. inappropriate, uncaring, unprofessional, irrelevant, unsubstantiated, exaggerated and disparaging, were commonplace words routinely used in everyday communication and did not require further definition. Although, she additionally relied upon a number of provisions of GMP and guidance entitled Leadership and Management for All Doctors (2012) and Personal Beliefs and Medical Practice (2013). Ms Kitzing contended that Dr Nadal was not simply required to be honest; he was a medical practitioner, registered with the GMC and was therefore subject to the duties expected of a registered medical practitioner. Ms Kitzing then referred the Tribunal to the evidence the GMC relied upon in support of each paragraph of the Allegation.

60. In response to Mr Edis's submissions, Ms Kitzing submitted that in bringing a case against Dr Nadal, the GMC was not, as had been submitted, seeking to extend the GMC's jurisdiction to regulate the insurance industry. She submitted that the Allegation related to Dr Nadal's status as a registered medical practitioner, not as an employee of an insurance company. Ms Kitzing acknowledged that Dr Nadal did not need to be on the medical register to perform his role, however the fact that he was a registered medical practitioner with a licence to practise required him to comply with GMP.

The Relevant Legal Principles

61. Rule 17(2)(g) of the Rules provides that:

> *'the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld'*

62. In determining whether there was sufficient evidence in respect all or any of the alleged facts, the Tribunal applied the test in *R v Galbraith* [1981] 73 Cr App R 124 ('*Galbraith*'). In *Galbraith*, Lord Lane LCJ said:

> *'How then should the judge approach a submission of 'no case'?*
>
> *(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*
>
> *(b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*

63. The Tribunal also had regard to the observations of Turner J in the case of *R v Shippey* [1988] Crim LR 767 and the principles set out in *R (on the application of Tutin) v GMC* [2009] EWHC 553 (Admin) with regards to submissions of no case within regulatory proceedings.

64. Throughout, the Tribunal reminded itself that it was not making findings of fact. Rather, the Tribunal was determining whether, taken at its highest, there was sufficient evidence on which a Tribunal *could* find the facts proved on the balance of probabilities.

The Tribunal's Decision

65. The Tribunal first considered Mr Edis's global submissions and then considered the sufficiency of evidence in relation to each paragraph of the Allegation, including those upon which Mr Edis had not made specific submissions on the evidence.

(1) Was there a duty?

66. It was the Tribunal's view that establishing whether or not Dr Nadal was under any duty was a question of law. The Tribunal considered that it was trite law that before any allegation that Dr Nadal had either failed to act, or had acted, in a certain way could be proved, it would first have to be established that Dr Nadal was under a relevant duty to act, or not act, as the case may be.

67. It was Mr Edis's submission that the GMC could not impose a duty on those working as 'Assistance Medics' who do not have to be doctors. It was submitted that the GMC had no role in the regulation of 'assistance medicine'. 'Assistance Medics' operate in a field that is unregulated and if Parliament had considered it necessary for this field to be the subject of regulation, it would have legislated accordingly. The Tribunal acknowledged that it would not be appropriate for the GMC to seek to prescribe the remit of 'Assistance Medics', as the insurance sector is a field that operates outside the scope of the GMC's regulatory powers. However, the Tribunal considered that Mr Edis's submission was misconceived because it was based upon a false premise.

68. In this case, the Tribunal was not being asked to determine the duties of an 'Assistance Medic', qualified or unqualified, in the insurance sector. The Tribunal was only required to determine what were the duties of a *registered and licensed medical practitioner* performing the role of an 'Assistance Medic' in the insurance sector.

69. Dr Nadal is currently, and was at all material times set out in the Allegation, a registered medical practitioner with a licence to practise. To maintain that status he is required to adhere to the duties of a GMC registered doctor, including participating in appraisal and revalidation processes. The Tribunal had regard to the Licence to Practise Factsheet that had been supplied by the GMC. The Factsheet clearly states *that 'all doctors registered with us, with or without a licence to practise, have a duty to comply with Good Medical Practice'*. The GMC is required to regulate all registered medical practitioners. In seeking to impose the duties of a registered medical practitioner on Dr Nadal, the GMC is acting entirely within its remit to regulate registered medical practitioners.

70. The Tribunal acknowledged that 'Assistance Medics' do not have to have a medical qualification to perform their role. Although, it did note that there was evidence that the EAF Medical Team for which Dr Nadal had a supervisory role comprised only doctors and nurses, some of whom were also in medical practice and were treating patients outside their 'Assistance Medic' role. In his role as an 'Assistance Medic', there was also evidence that Dr Nadal utilised his own medical knowledge and experience as a registered medical practitioner. In these circumstances, the Tribunal considered that although Dr Nadal was employed in the capacity of an 'Assistance Medic' by an insurance company that did not require him to be a registered medical practitioner, because he was a registered medical practitioner, he was subject to the same duties imposed by GMP to which all registered doctors must comply.

71. GMP itself makes plain that its provisions are not limited to those practitioners engaged in clinical practice, providing treatment and care to patients, but applies to all manner of work in which a medical practitioner may engage. GMP provides:

> ***4*** *You must use your judgement in applying the principles to the various situations you will face as a doctor, whether or not you hold a licence to practise, whatever field of medicine you work in, and whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.*
>
> ***7*** *You must be competent in all aspects of your work, including management, research and teaching.*
>
> ***14*** *You must recognise and work within the limits of your competence.*

33 You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.

34 When you are on duty you must be readily accessible to patients and colleagues seeking information, advice or support.

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

36 You must treat colleagues fairly and with respect.

54 You must not express your personal beliefs (including political, religious and moral beliefs) to patients in ways that exploit their vulnerability or are likely to cause them distress.

72. In the judgment of the Tribunal, Dr Nadal was subject to all of these duties by virtue of his status as a registered medical practitioner and that he should have complied with them in the course of his work as an 'Assistance Medic' and specifically in relation to his involvement with Patient A, Patient B, Patient D, their families (and Ms E) on behalf of EAF even though they were not his patients.

73. The Tribunal also considered, though it was unnecessary for its conclusion, whether a registered medical practitioner performing the role of an 'Assistance Medic' providing advice to an insurer as to the necessity or otherwise of repatriating an insured for medical treatment would owe a duty to the insured, notwithstanding the absence of any contract between the 'Assistance Medic' and the insured. The Tribunal considered that an 'Assistance Medic' as described would in all probability owe a common law duty of care to the insured.

74. Having concluded that Dr Nadal was subject to the duties imposed by GMP, the Tribunal went on to consider what was the nature and extent of that duty in the context of his role as an 'Assistance Medic' and by what standard should the performance of his duty be measured.

2) By what standard should any identified duty be measured?

75. At the heart of Mr Edis's submission was the proposition that there was no *'admissible'* evidence as to the standard by which Dr Nadal should have been performing as

an 'Assistance Medic'. He submitted that Dr Nadal could only properly be judged against the standards reasonably to be expected of other 'Assistance Medics' operating in the insurance sector. He submitted that given that both of the GMC experts had no knowledge or experience in the field, and that they were applying the standards of clinicians, in the case of Dr P, a Consultant and in the case of Dr Q, a registered medical practitioner, they were applying the wrong standard and one which Dr Nadal could not be expected, or required to achieve.

76. The Tribunal did not agree with this submission. For the reasons already given, the Tribunal considered that Dr Nadal was under a duty to comply with GMP and that the standard against which his conduct should be measured was the standard reasonably to be expected of a *registered and licensed medical practitioner* performing the role that Dr Nadal was purporting to perform as an 'Assistance Medic'.

77. The Tribunal noted that there was evidence as to the role that Dr Nadal was performing from a number of sources. In particular, Dr Nadal's own description of his work contained within an appraisal document dated 29 September 2018, which stated in the 'Scope of Work' section:

> *'…My role is to act as Medical Director leading a Medical Team consisting of four full-time doctors, two nurses and two part-time doctors. The Medical Team (MT) advises a trading entity within tifgroup that is called Emergency Assistance Facilities (EAF); The MT's role is to advise EAF as to when and how to repatriate or transfer insured clients. The doctors are not allowed to direct or interfere with care or to do anything that might result in the doctor acquiring clinical responsibility. No member of the team is allowed ever to see a client or provide any service to them such as acting as a medical escort. Such roles are fulfilled by those contracted by the insurer, usually through third party suppliers. In essence, the assistance company's doctors' role is to understand the pathophysiology of disease or injury, as well as the aviation or ambulance environment, and to prevent EAF from inadvertently causing harm to a client by transferring him in a dangerous manner or at the wrong time. The doctors need also to understand foreign medical practices and legal jurisdictional matters that can affect how EAF discharges its contractual obligations to the insured on behalf of the insurer…'*

78. The Tribunal acknowledged that whilst both GMC experts did not have experience in the field of 'assistance medicine' working in the insurance sector, that they nonetheless had

far greater qualification and experience than Dr Nadal. Further, their experience was direct clinical experience in all aspects of undertaking aeromedical transfers. However, the Tribunal was not persuaded that this disqualified them from opining upon the minimum standards reasonably to be expected of a registered medical practitioner performing the role as described by Dr Nadal himself.

79. The experts both had extensive experience of repatriation decision-making of a type similar to that which Dr Nadal was required to undertake, and was undertaking, albeit not in the context of advising an insurer as to whether an aeromedical transfer was medically necessary for an insured.

80. Accordingly, the Tribunal considered that the opinion evidence of both experts was admissible by virtue of their having sufficient expertise of the matters upon which they were opining.

81. As to the appropriate standard, the Tribunal considered carefully the evidence that Dr P had given in relation to the standard against which she had judged Dr Nadal and which had been subject to extensive criticism by Mr Edis. The Tribunal acknowledged that within the reports provided by Dr P that there was a degree of confusion as to the standard that she was applying. She appeared, at different times, to have considered three possible standards, Consultant Anaesthetist, 'General Consultant' and a 'Transfer and Retrieval Practitioner'.

82. The Tribunal accepted that this was not entirely the fault of Dr P given the incorrect CV supplied on behalf of Dr Nadal and this had impacted on the instructions given to Dr P by the GMC. Nevertheless, the Tribunal considered this apparent confusion unfortunate and unhelpful. However, the Tribunal had regard to Mr Edis's extensive cross-examination of Dr P upon this issue. It determined that a Tribunal could conclude on the basis of her evidence that the standard she had ultimately applied was that of a 'General Consultant' and, on one view of the evidence, this was an appropriate standard against which to judge Dr Nadal having regard to the experience set out in his CV and appraisal document and the senior position that he occupied in his capacity as a Medical Director with a supervisory role over other doctors. The Tribunal considered that, on the basis of the evidence adduced thus far, a properly directed Tribunal could conclude that a Consultant-level, i.e. a senior doctor as described by Dr P, would be an appropriate comparator and standard against which Dr Nadal's conduct should be judged. This would be the highest standard against which Dr Nadal's conduct could be judged.

83. With regard to Dr Q, the Tribunal considered that he having measured Dr Nadal against the standards of a registered medical practitioner, this was, in the circumstances, an appropriate standard to apply. This would have been the minimum standard against which the conduct of Dr Nadal should be judged.

84. Furthermore, the Tribunal considered that both experts were more than qualified to assess what information Dr Nadal would require in order to make an adequate risk/benefit analysis when deciding whether a patient required repatriation by air ambulance for treatment or whether they should be treated at their location at the time and the risks that transfer by air ambulance would entail. Both experts were in a position to comment on the need to obtain all the relevant information including a risks/benefits analysis of the patient's location at the time, where it might be proposed they are moved to and what moving the patient would involve.

85. The Tribunal accepted, as was Dr Q's evidence, that Dr Nadal could not necessarily be expected to have any specific knowledge, qualification or experience in relation to specific patients' medical needs or any specific practical issues involved in an aeromedical transfer. However, his role did require him to find out what information was required and appreciate those matters upon which he needed to obtain expert advice, be it treating clinicians or those who would be directly responsible for the aeromedical transfer. Further, he would need to obtain such advice in such time as the circumstances allowed or demanded. The Tribunal considered that invariably the fact that an aeromedical transfer was being considered would mean that the patient was in urgent need of medical treatment/care.

86. The Tribunal having considered that there was sufficient evidence upon which a duty could be established and there was evidence upon which the appropriate standard could be identified from the evidence of the experts, it necessarily followed that their opinion evidence was admissible and capable of proving the alleged breaches of duty.

87. With regard to the paragraphs of the Allegation concerning inappropriate/unprofessional communications the Tribunal determined that, as a registered medical practitioner, and by virtue of the provisions of GMP referred to above, Dr Nadal was not simply under a duty to be honest and candid, but he was also required to communicate appropriately and professionally when dealing with patients' families and others. The Tribunal further considered that what might, or might not, be regarded as appropriate in any given circumstance would necessarily be fact-specific and much would depend on context. Nevertheless, the Tribunal considered that this was a topic upon which expert opinion

evidence would be admissible and that Dr Q was qualified to give his opinion in the present case from the perspective of a registered medical practitioner.

88. Mr Edis had criticised the experts for failing to adhere to their own duties as expert witnesses as set out in the Civil Procedure Rules *'Guidance for the instruction of experts in civil claims'* and the GMC's own guidance for expert witnesses. The Tribunal having rejected the overarching objection regarding the admissibility of their evidence, considered each of the other criticisms detailed by Mr Edis in his skeleton argument and orally. The Tribunal considered that the criticisms, either individually or cumulatively, taken at their highest, could only impact upon the weight that might be attached to their evidence.

89. Accordingly, the Tribunal considered that there was sufficient evidence to establish Dr Nadal's duties, the standard against which his actions should be measured and any breaches of those duties to the extent that the Tribunal could accept the opinion evidence of the experts and to the extent that there was sufficient evidence of the primary facts. It was therefore open to a Tribunal to accept the expert evidence in relation to relevant paragraphs of the Allegation. The Tribunal went on to consider each paragraph of the Allegation in turn and assess whether there was sufficient evidence of fact adduced by the GMC, when taken at its highest, to find each paragraph proved.

Patient A

1. On 16 March 2016 your decision not to repatriate Patient A was inadequate in that you failed to:

    a. ascertain the level of care being provided at the host hospital ('Myung Sung Medical Centre') in respect of:

        i. medical and nursing staff; To be determined
        ii. clinical facilities; To be determined
        iii. cleanliness; To be determined
        iv. treatment options available; To be determined

    b. ascertain whether a better level of care could be provided on the African sub-continent resulting in reduced transfer times;
    To be determined

c. adequately assess the risk versus benefit of aeromedical transfer taking into account the factors as set out in paragraphs 1.a and/or 1.b.
To be determined

90. Paragraph 1 of the Allegation related to Dr Nadal's involvement in Patient A's case on 16 March 2016. Indeed, there was no evidence to suggest that Dr Nadal had any other involvement in Patient A's case on any other day. It related to Dr Nadal's apparent endorsement of a decision by the insurers (TIF) that it would not assume the responsibility for repatriating Patient A to the UK at that time.

91. Up until 16 March 2016, another member of the EAF Medical Team, Dr F, had responsibility for Patient A's case and for liaising with Patient A's family and the treating surgeon at Myung Sung Medical Centre. Although, there was some evidence from which the Tribunal could conclude that Dr Nadal, as Medical Director, had some supervisory responsibilities for the Medical Team. The GMC had not sought to suggest that Dr Nadal's alleged failing in respect of Patient A were a result of any failure by him to supervise his Medical Team colleagues, in this case Dr F. Nor was it alleged that Dr Nadal was somehow vicariously responsible for any possible failings of the Medical Team or any of those he may have supervised. On the contrary, the GMC conceded, rightly in the Tribunal's judgment, that the Allegation related to Dr Nadal's individual involvement and responsibilities in the cases of Patient A, Patient B and Patient D. Furthermore, the GMC did not seek to suggest that Dr F was not suitably qualified or experienced to deal with Patient A's case. There was some evidence to suggest that Dr F had previously worked as a Consultant in a Neuroscience Centre at a London Teaching Hospital.

92. The Tribunal had regard to the evidence before it relating to Patient A.

93. Dr Nadal's first and only documented involvement in Patient A's case was on 16 March 2016. It appears that Dr Nadal became involved following a conversation between Dr F and Mr BA, Patient A's son. Dr F told Mr BA that it was not safe to repatriate Patient A given the swelling of his brain. Mr BA was not satisfied with his conversation with Dr F so Dr F decided to refer the case to Dr Nadal to review. Dr F's note in the EAF call log says *'Plan, MJN* [Dr Nadal] *to review asap'*. While it appears that Dr Nadal did review the case at Dr F's request, there was no evidence before the Tribunal as to what Dr F told Dr Nadal about Patient A's case. However, the Tribunal considered that there was some evidence from which it could reasonably be inferred that Dr F had reiterated the view he had expressed to the treating clinician, Dr J, and to which Dr J did not disagree, and to Patient A's family that

Patient A's post-operative condition was such that he was unfit for any aeromedical transfer *at that time*. There was evidence that Dr F did consider that it would be appropriate to transfer Patient A to the UK by air as and when his medical condition allowed. On 16 March 2016, Dr Nadal spoke with Mr BA and endorsed Dr F's decision that EAF would not be arranging the repatriation of Patient A at that time.

94. The Tribunal was not provided with any evidence as to the nature or extent of any review conducted by Dr Nadal. The GMC specifically alleged that any review completed by Dr Nadal should have included the matters set out in paragraphs 1.a and 1.b of the Allegation. It was the GMC's case that if Dr Nadal had failed in this regard, he would have failed to adequately assess the risk versus benefit of aeromedical transfer (paragraph 1.c). In this respect the GMC relied upon the evidence of Dr P as set out in her reports.

95. The Tribunal considered whether there was evidence to show that Dr Nadal should have ascertained Patient A's level of care being provided by the host hospital (Myung Sung Medical Centre) and ascertained whether better care could be provided elsewhere on the African *'sub-continent'* [sic].

96. The Tribunal had regard to Dr P's expert evidence. In oral evidence, during Tribunal questions, Dr P said:

> *'Q I think you agreed that sometimes it is a very finely balanced decision. But are there not occasions where actually there isn't a finely balanced decision to make in the sense that there may be a particular, for example, benefit to the patient staying where they are, or a particular risk to their being moved which really outweighs if not all but nearly all other considerations?*
>
> *A Yes, sir. That's what the key is. You would never move someone to a lower level or you would never move them if you were putting them at an increased risk. So the whole reasoning behind repatriation and transfer medicine is that you take patients from a standard level of care that they're receiving to receive a definitive level of care or a higher level of care.'*

97. When given a specific scenario aligning with the facts of Patient A's case, Dr P said:

> *'Q Now just moving slightly closer to the facts of this case, but making assumptions. If it were the case that* [Dr F] *had formed the opinion – and let's assume*

it was an opinion he was entitled to form – but if he had formed the professional opinion that a gentleman of this age, who had had a major haemorrhage, who had had surgery in the last 48/72 hours, and had a midline shift of the order of 7 mm, perhaps decreasing to 5 mm, should not travel in a plane because it would, at the very least, in his opinion, cause further brain damage and, at worst, kill the patient. If that were the view that he had taken, if that was his professional opinion, would it really be necessary, in those circumstances, for him to consider the state of cleanliness, for example, of the hospital where the patient was? Bearing in mind this – and this is the final part of the scenario – bearing in mind this, that he would have known that Patient A was in a hospital which was capable of performing brain surgery, was, on the face of it, capable of performing brain surgery successfully to the extent that the patient has come out of surgery and is receiving post-operative care, and that it is a hospital where they have CT scans and where there is, at least to that extent, the means of measuring progress during the post-operative period? If that's the scenario, when it comes to whether or not consideration should have been given – and let's say by [Dr F] *– to the cleanliness or the precise facilities available, would you think that that was a necessary thing for him to do?*

A I think in the short term no because, you know, the patient was where he was going to be and that's what had happened to him. I think, you know, he mentioned that maybe in two weeks' time we could move the patient, but then it's thinking about that interim and that is where the facilities that are available become so important. It's not so much the cleanliness, it's the general care that the patient receives, because that can be make-or-break. So if he's survived that first week, if he's still in somewhere where the procedures are particularly good, they're not monitoring or minimising further infection, further deterioration, then that could have an adverse effect on that patient. So, yes, for the initial decision reasonable, but that's why it's so important to take account of the bigger environmental picture because, you know, if Patient A had have survived a bit longer then the care is going to get further and further detrimental. That's what so important about getting your ducks in a row, so if you do get the opportunity, you can move somebody out in a safe way.'

98. Dr P's oral evidence was that it would only have become relevant to consider the factors set out in paragraphs 1.a and 1.b of the Allegation once Patient A had remained stable up to one week following his operation. It would not have been safe to move Patient A in any event so soon after the surgery to evacuate his haematoma. In light of this evidence, the Tribunal considered that, on 16 March 2016, Dr Nadal was not under a duty to ascertain the

information alleged relating to Patient A's level of care. The Tribunal understood Dr P's evidence to concede that as at 16 March 2016, Patient A was not fit for aeromedical transfer, either to the UK or elsewhere (including on the African *'sub-continent'* [sic]) and although the matters identified in paragraphs 1.a and 1.b would have been relevant considerations on a future date, and in the event of an improvement in Patient A's condition, they were not at the relevant time.

99. Accordingly, the Tribunal determined that there was not sufficient evidence to conclude there was a case to answer in respect of paragraph 1 of the Allegation.

100. In reaching this conclusion, the Tribunal acknowledged the criticisms levelled at EAF and specifically the Medical Team by Patient A's wife and son. Indeed, the Tribunal accepted that it might be considered that EAF/the Medical Team had not been sufficiently proactive and responsive to Patient A's family's desire for Patient A to be repatriated. The Tribunal accepted that they may have had good reason for being concerned at the facilities available and standard of care provided to Patient A at the Myung Sung Medical Centre. Furthermore, the family had understood that it had been the view of Dr V, who was not the treating clinician at the relevant time, and the view of the treating clinician, Dr J, as expressed to them, that Patient A was fit to transferred by air ambulance. However, having had regard to the evidence, the Tribunal concluded that there was insufficient evidence for any valid criticism that there may have been to be laid at the door of Dr Nadal whose personal involvement in the case, the evidence suggests, was very limited.

Patient B

2. Between 30 June and 9 July 2017, your ongoing decision-making relating to the repatriation of Patient ~~XX~~ B was inadequate in that you failed to:
   Amended under Rule 17(6)
   To be determined

   a. obtain any medical information regarding Patient B's clinical condition until 7 July 2017;
      To be determined

   b. have the Turkish medical report received on 4 July 2017 translated in the UK;
      To be determined

c. monitor Patient B's treatment and progress at the host hospital ('Yucelen Hospital Mugla');
To be determined

d. discuss Patient B's case with:

i. his UK Consultant Haematologist ('Dr C') to utilise the specialist advice being offered to you; To be determined

ii. an air ambulance company for advice about the risks of repatriation; To be determined

e. pursue early aeromedical repatriation having regard to:

i. Patient B having a complex, rare and life-threatening condition that required specialist care; To be determined

ii. the necessary clinical expertise on Patient B's condition not being available at the host hospital; To be determined

iii. the host hospital and / or treating clinician being reluctant to facilitate Patient B's transfer to the state hospital ('Mugla State University Hospital'). To be determined

101. In respect of paragraph 2.a of the Allegation, the Tribunal considered, what, taken at its highest, the evidence could establish regarding the chronology of events and specifically in regard to Dr Nadal's involvement in Patient B's case.

102. Dr G initially had conduct of Patient B's case. EAF received an email on 3 July from the Yucelen Hospital Mugla that stated Patient B's situation was *'serious'* and air ambulance transportation was required. The EAF event log recorded that Dr G discussed Patient B's case with Dr Nadal on 5 July 2017. The log also records that the medical report that had been received was in Turkish. The evidence suggests that thereafter Dr Nadal had conduct of the case, Dr G having gone on leave. There was nothing in EAF's records to suggest that Dr Nadal had, himself, sought to obtain any medical information regarding Patient B's clinical condition prior to 7 July 2017 notwithstanding the content of the email received on 3 July 2017.

Furthermore, in the interim, Dr C, Patient B's UK Consultant Haematologist, had faxed through a letter dated 5 July 2017 to EAF stating that he needed to be repatriated for treatment. The letter stated that Patient B had a *'life threatening haematological condition'* that required specialist care urgently and expressing Dr C's opinion that any further delay in repatriating Patient B *'might seriously affect chances of survival'*. In view of the above, coupled with the expert evidence of Dr Q, the Tribunal was satisfied that there was sufficient evidence upon which a Tribunal, properly directed, could find paragraph 2.a of the Allegation proved.

103. In respect of paragraphs 2.b, 2.c, 2.d, 2.e.i and 2.e.ii of the Allegation, the Tribunal again had regard to the chronology of events set out in the EAF event log.

104. The email received by EAF on 3 July 2017 appeared to have attached to it a medical report, the attachment was titled *'*[Patient B] *TURKISH REPORTS'*. The Tribunal was not provided with a translated copy of the attached report but was satisfied that a properly directed Tribunal could infer that the medical report attached was the one which required translation and detailed the need for transportation by air ambulance. Although, this email was received before Dr Nadal was involved in Patient B's case, from 5 July 2017 onwards it could be inferred that Dr Nadal was involved having taken over the case from Dr G.

105. On 7 July 2017, the EAF event log records that Dr G discussed Patient B's case further with Dr Nadal. The Tribunal considered that from the evidence adduced, it could, at the very least, be inferred that from 5 July 2017 onwards, Dr Nadal knew that there was a medical report in Turkish and that repatriation was being suggested by the host hospital and, by 5 July 2017, by Dr C as well. There was evidence in the EAF event log that demonstrated that other EAF staff members took steps to have the medical report translated. There was, however, no evidence that Dr Nadal sought to chase a translated report, notwithstanding that there was evidence that he had taken over the case from Dr G and a need for urgency had been expressed.

106. Further, on 9 July 2017, there are a number of entries in the EAF event log that confirm Dr Nadal was aware of, and had reviewed, Patient B's case. Dr Nadal's entry on 9 July 2017 at 21:53 states:

> *'MJN* [Dr Nadal] *has read the file. He notes that* [Patient B] *is still in private hospital; his condition required public university hospital. MJN has seen no evidence of* [Patient B]

having declared his PMH [past medical history] *nor of his case having been escalated to establish cover. This must be done as a matter of urgency without fail.'*

107. The Tribunal considered that from the evidence provided, and taken at its highest, a Tribunal could conclude that by the evening of 9 July 2017, Dr Nadal had familiarised himself with Patient B's case file. Therefore, it might be inferred that he would have been, or ought to have been, aware of a perceived need by the treating clinician at the host hospital and Dr C, Patient B's UK Consultant Haematologist, of an aeromedical transfer. Nevertheless, it might be inferred, that Dr Nadal's own enquiries were limited to establishing the nature of Patient B's insurance coverage i.e. whether Patient B was covered under the terms of his policy and whether he had declared his past medical history. In these circumstances, having regard to the expert evidence of Dr Q, it considered a Tribunal could infer that Dr Nadal had not given consideration to the need to obtain a translated medical report nor whether there was an urgent need for repatriation. In light of the chronology from the EAF event log and the absence of any evidence that Dr Nadal had himself sought to obtain a translated copy of the medical report sent through in Turkish to EAF on 3 July 2017, the Tribunal considered that there was sufficient evidence for a Tribunal, properly directed, to find paragraph 2.b of the Allegation proved.

108. The Tribunal was satisfied that, in respect of paragraph 2.c, it could be considered there was a duty on Dr Nadal, in the circumstances of Patient B's case, to obtain information from the host hospital. The EAF event log provided, together with the evidence of Ms B and Ms BB, sufficient evidence for a Tribunal to conclude that Dr Nadal did not make such enquiries and therefore a Tribunal, properly directed, could infer that Patient B's treatment and progress was not monitored by Dr Nadal. There was no evidence within the EAF event log or elsewhere to indicate that Dr Nadal was monitoring Patient B's treatment and progress at the host hospital.

109. In relation to paragraph 2.d of the Allegation, the Tribunal was satisfied that, in view of Dr Q's expert opinion, there was sufficient evidence to conclude that Dr Nadal had a duty to discuss Patient B's case with Dr C. It was satisfied that there was sufficient evidence, including Dr C's witness statement, oral evidence and correspondence with EAF, for a Tribunal, properly directed to conclude that Dr Nadal had failed to discuss Patient B's case. The Tribunal considered whether, as had been submitted, Dr Nadal's failure to discuss Patient B's case with Dr C could be justified on the grounds that Dr C's letter 5 July 2017 was, in Dr Nadal's view, *'unhelpful'* as he had told Ms BB and as had been put to Dr C in cross-examination. The Tribunal considered that if this was Dr Nadal's assessment, it might have

provided all the more reason for him to have contacted Dr C. Further, it was satisfied that in Dr Q's opinion, Dr Nadal should have discussed Patient B's case with an air ambulance company for advice about any risks of repatriation and that there was sufficient evidence to prove that Dr Nadal should have had such a discussion and failed to do so.

110. In relation to paragraph 2.e.i and 2.e.ii of the Allegation, having regard to the EAF event log, and documents setting out Dr Nadal's involvement in Patient B's case, the Tribunal was satisfied that there was sufficient evidence for a Tribunal, properly directed, to find proved that Dr Nadal had failed to pursue early aeromedical repatriation.

111. Regarding paragraph 2.e.iii of the Allegation, the Tribunal found that there was no evidence that Dr Nadal was aware that the host hospital and/or Patient B's treating clinician were reluctant to facilitate Patient B's transfer to the state hospital. The Tribunal considered that Dr Nadal could only have been under a duty to have regard to the apparent reluctance of the host hospital if there was evidence that he was, or should have been, aware of it. Ms B's evidence was clear that she had been told by the host hospital (correctly or otherwise) that an ambulance was not available to transfer Patient B from the private hospital to the public hospital in Mugla. However, there was no evidence to suggest that Dr Nadal or EAF had been made aware of the private hospital's apparent reluctance/inability to provide an ambulance. Accordingly, there was no evidence to suggest that Dr Nadal had been made aware by Ms B, of the host hospital's apparent reluctance or that they had otherwise been informed of any such reluctance/inability to provide an ambulance by the private hospital. In these circumstances, the Tribunal did not consider that there was any evidence that Dr Nadal was aware of this fact or, given that Patient B had been transferred by ambulance to the host hospital from another hospital previously, he should have been aware of any difficulties regarding inter-transfer hospital by ambulance.

112. Therefore, the Tribunal concluded that there was not sufficient evidence to find paragraph 2.e.iii of the Allegation proved.

3. From 5 July 2017 onwards, your care of Patient B was inadequate in that you failed to:

    a. ensure the telephone calls from Patient B's family were returned in a timely manner; To be determined

    b. return Dr C's telephone calls. To be determined

113. The Tribunal had regard to the EAF event log, as well as the evidence of Patient B's family members and Dr C. The Tribunal was satisfied that EAF appeared to have a system in place whereby calls that were received were logged. As such, it might be inferred that a system was in place to ensure that messages were seen by the people they were intended for, including Dr Nadal and the Medical Team. In light of the evidence from the EAF event log and the evidence of Ms B and Ms BB, the Tribunal considered that a Tribunal, properly directed, could conclude that there was sufficient evidence to find paragraph 3 of the Allegation proved. Specifically, with regard to the paragraph 3.b of the Allegation concerning the failure of Dr Nadal to return Dr C's telephone calls, the Tribunal considered that, notwithstanding the absence of a log of Dr C's calls, it could be inferred, in absence of evidence to the contrary a message would have been, or ought to have been, seen by Dr Nadal, and the calls were not returned. Accordingly, the Tribunal concluded that a properly directed Tribunal could find paragraph 3.b of the Allegation proved.

4. On 10 July 2017, your communication with Patient B's family was inappropriate in that:

    a. your attitude was uncaring and unprofessional; To be determined

    b. you gave advice about blood transfusion which served no purpose; To be determined

    c. you shared an unprofessional opinion about:

        i. Dr C's letter dated 5 July 2017 being very unhelpful to you; To be determined

        ii. the ability of Worthing Hospital to manage Patient B's condition effectively; To be determined

    d. you did not end your conversation with a definitive plan:

        i. about the transfer; To be determined

        ii. when you would contact Patient B's family again and /or when further contact would be made. To be determined

114. In respect of paragraphs 4.a, 4.b and 4.c of the Allegation, the Tribunal was satisfied that having identified the relevant duty and having been provided with the transcripts and audio recordings of Dr Nadal's calls with Patient B's family, there was sufficient evidence for a Tribunal, properly directed, to find those paragraphs of the Allegation proved.

115. The Tribunal acknowledged that an assessment of the appropriateness and/or professionalism of Dr Nadal's communications might require consideration of the context in which Dr Nadal was speaking to Patient B's family and his reasons for dealing with the matters that it is alleged he dealt with inappropriately and/or unprofessionally in the manner he did. However, in the absence of any other evidence of context or Dr Nadal's reasons for dealing with the matters as he did, the Tribunal considered that there was sufficient evidence, at this stage, upon which a Tribunal could find paragraphs 4.a-c of the Allegation proved.

116. In respect of paragraph 4.d. of the Allegation, that Dr Nadal's communication with Patient B's family was inappropriate in that he ended the call without a definitive plan, the Tribunal had regard to Dr Q's oral evidence:

> *'Q It says in relation to about the transfer and then it says "when you would contact Patient B's family again or when further contact would be made". Given the content of the conversation that you have been referred to, if it were said that Dr Nadal was saying as much as he could say at that time, he did so?*
>
> *A …I mean, obviously he's given quite a long-winded answer but that's fine. So, she says "talking over the next couple of days", and he says:*
>
> *"Well I mean it could be tomorrow, it won't be today ... for sure."*
>
> *I think, in fairness, at that point in time he couldn't be more specific and I don't think that was an unreasonable answer. I do think it would have been good practice to say, "But let's keep in contact with you every day and I'll update you as soon as I know". Had that happened, then that would have been a gold standard answer.'*

117. In light of Dr Q's expert opinion that Dr Nadal's lack of a definitive plan did not fall below the standard expected of him, the Tribunal concluded that there was not sufficient evidence to find paragraph 4.d of the Allegation proved.

Patient D

5. Between 28 February and 4 March 2018, your care of Patient D was inadequate in that you failed to make any direct contact with the treating clinician to monitor Patient D's clinical condition and progress.
To be determined

118. The Tribunal had regard to the EAF event log and there was no record of Dr Nadal having had direct contact with Patient D's treating clinician between 28 February 2018 and 4 March 2018. The Tribunal noted that Dr Nadal had attempted to speak to Patient D's treating clinician on 5 March 2018 but was only able to speak to a nurse on that occasion. Taking all the evidence at its highest, it would appear that Dr Nadal spoke to Patient D's treating clinician once, on 6 March 2018. Based upon the documentary evidence and Dr Q's evidence that such a contact should have been made earlier, the Tribunal concluded that a Tribunal, properly directed, could find paragraph 5 of the Allegation proved.

6. From 21 February 2018 onwards, your decision not to repatriate Patient D was inadequate in that you failed to:

   a. have sufficient regard to the fact Patient D:

      i. had suffered a major cardiac event on the background of chronic cardiac disease; To be determined
      ii. had a life-threatening condition; To be determined
      iii. did not initially have a rapidly deteriorating condition; To be determined
      iv. would likely need to wait at least a month for cardiac catheterisation locally; To be determined
      v. would require helicopter transfer to another island for cardiac catheterisation at the Dr Negrin Hospital; To be determined

119. The Tribunal, having concluded that there was sufficient evidence to find that Dr Nadal had a duty, derived from and consistent with paragraph 4 of GMP, to perform a risk/benefit analysis. Further, it considered that the evidence of the witnesses of fact and the expert opinion evidence of Dr Q was sufficient evidence upon which a Tribunal, properly directed, could find paragraphs 6.a.i-6.a.iv proved.

120. In reaching this conclusion the Tribunal had regard to the detailed cross-examination of both Dr Q and the factual witnesses relating to paragraphs 6.a.i to 6.a.iv of the Allegation and reminded itself that at this stage it is taking the evidence at its highest and that it had not heard evidence from either Dr Nadal, nor his expert, Professor R.

121. In respect of paragraph 6.a.v of the Allegation, the Tribunal considered Dr Q's evidence. Dr Q had first reported that it was his understanding that the transfer of Patient D from Lanzarote to Gran Canaria would have been by helicopter rather than a fixed wing aircraft. Dr Q was subsequently provided with Dr Nadal's witness statement, in which Dr Nadal asserted that transfers between Lanzarote and Gran Canaria were undertaken by a fixed wing aircraft and not a rotary wing aircraft. Dr Q conceded that he had no reason to doubt this assertion but that he had understood such transfers to be by way of rotary wing aircraft (helicopter) because of something he had read in the papers but which he could not now recall.

122. Dr Q accepted that if the transfer would have been by a fixed wing aircraft, this fact would not have been a significant matter in the assessment of whether Patient D should have been repatriated to the UK as opposed to receiving treatment in Gran Canaria. The only evidence the GMC was able to rely upon in support of paragraph 6.a.v, that a transfer would have involved a helicopter was a reference in correspondence from Ms E, a consular official (who did not give evidence). That correspondence stated that hospitalised patients were *'usually'* transferred from one island to another in a helicopter. The Tribunal considered that taking this evidence at its highest, it fell short of being capable of establishing, on the balance of probabilities, that Patient D's transfer would necessarily have required a helicopter transfer as alleged.

123. Accordingly, the Tribunal concluded that there was no case to answer in respect paragraph 6.a.v of the Allegation.

b. have sufficient regard to the treating clinicians view that Patient D:

i. required urgent catheterisation with or without treatment; To be determined

ii. would die without cardiac catheterisation, as related to you by the Consulate Representative (Ms E); To be determined

124. The Tribunal, having had regard to the documentary evidence, the witnesses of fact, and Dr Q's expert opinion evidence, considered that there was evidence upon which a Tribunal could properly conclude that Patient D's treating clinician had expressed the view that Patient D required urgent cardiac catheterisation and that this was a fact to which Dr Nadal should have had regard to but which it could be inferred he had not. Therefore, the Tribunal was satisfied that there was sufficient evidence for a Tribunal, properly directed, to find paragraph 6.b.i proved.

125. The Tribunal then considered paragraph 6.b.ii of the Allegation. It had regard to the evidence of Ms D, Ms DD and the notes written by Ms E, who had not given evidence. The Tribunal bore in mind that the evidence to support this paragraph of the Allegation was hearsay and related to an interpreted conversation from Spanish to English primarily between Ms E and Patient D's treating clinician. In light of the evidence from both Ms D and Ms DD, at least one of whom was present on the telephone call with Ms E and Patient D's treating clinician, the Tribunal considered that the evidence to support paragraph 6.b.ii was not so tenuous as to prevent a Tribunal, properly directed, from finding the Allegation proved. As such, it concluded that there was a case to answer.

c. have sufficient regard to the limited cardiology facilities at the host hospital ('General Hospital Arricefe'); To be determined

126. The Tribunal considered that the evidence demonstrated, and the GMC had not suggested otherwise, that Dr Nadal had appreciated the need to transfer Patient D to a hospital with better cardiology facilities. However, the issue at the relevant time was whether Patient D should be transferred to a public hospital on Gran Canaria or repatriated to the UK for treatment at a hospital there. Accordingly, the Tribunal concluded that there was no evidence to suggest that Dr Nadal had failed to have sufficient regard to the limited facilities at the host hospital. As such, the Tribunal concluded that there was no case to answer in respect of paragraph 6.c of the Allegation.

d. seek advice from:

i. the treating clinicians; To be determined
ii. a UK cardiologist; To be determined
iii. an air ambulance company; To be determined

127. The Tribunal was satisfied that, on the basis of Dr Q's expert opinion evidence, a Tribunal properly directed could conclude that Dr Nadal had a duty to seek advice from: the treating clinician(s) as to the treatment Patient D was receiving and that which he would require in the future; a UK cardiologist, as to the treatment Patient D could obtain in the UK and how quickly; and an air ambulance company as to whether Patient D could be safely transferred.

128. In respect of paragraph 6.d.i, the Tribunal accepted that Dr Nadal had had a conversation with Patient D's treating clinician and had regard to the transcript of the call. However, it considered that a Tribunal, properly directed, could conclude that whilst a conversation had taken place, Dr Nadal was not seeking advice. In respect of paragraph 6.d.ii, the Tribunal considered that there was no evidence that Dr Nadal had contacted a UK cardiologist though, on the basis of Dr Q's expert opinion, he had a duty to obtain advice in order to perform the necessary risk/benefit analysis. In particular, from the evidence, a Tribunal could find that advice should have been sought in order to obtain the likely waiting time for an urgent cardiac catheterisation in the UK and to establish whether it could be performed sooner than the anticipated time it would take in Gran Canaria. In respect of paragraph 6.d.iii, the Tribunal considered that it would open for a Tribunal, properly directed, to conclude based on the expert evidence of Dr Q and the lack of evidence to suggest an air ambulance company was contacted for advice, paragraph 6.d.iii could be found proved.

e. adequately assess the risk versus benefit of aeromedical transfer by taking into account the factors as set out in paragraphs 6.a to 6.d.
To be determined

129. Having concluded that there was a case to answer in respect of paragraph 6.a, 6.b and 6.d, there was a case to answer in respect of paragraph 6.e of the Allegation, aside from any consideration of paragraph 6.c.

7. On 28 February and 1 March 2018, your communication with Patient D's family was inappropriate in that you:

a. justified why air transfer to the UK was not possible by giving irrelevant, unsubstantiated and / or exaggerated risks regarding the air environment being:

i. low in pressure; To be determined

ii. low in oxygen; To be determined
iii. extremely dry; To be determined
iv. very high in ozone concentrations; To be determined
v. subject to acceleration forces; To be determined

b. claimed if you approved air transfer and Patient D died enroute, you might face manslaughter charges; To be determined

c. provided your personal political views on healthcare within the EU and the UK which had no relevance to Patient D's care; To be determined

d. provided observations about Spanish private health care facilities that may not have been appropriate; To be determined

e. made disparaging remarks about the input of Consular staff and knowledge of aviation medicine of specific nationalities; To be determined

f. stated delays for cardiac intervention in the UK were the worst in Europe; To be determined

g. mentioned other cases of repatriation in which the patient died; To be determined

h. stated that the UK government delayed issuing Provisional Replacement Certificate to reduce costs; To be determined

130. The Tribunal had already concluded that Dr Nadal had a duty to ensure his communications were appropriate and professional. The Tribunal considered the evidence of Ms D, the transcripts and recordings of her telephone calls with Dr Nadal from 28 February and 1 March 2018. It concluded that there was sufficient evidence for a Tribunal, properly directed, to find paragraphs 7.a-h of the Allegation proved.

131. Again, the Tribunal considered that the appropriateness of the matters communicated as alleged would depend upon their context and any reasons Dr Nadal had for conveying the information in the manner he did. Nevertheless, the Tribunal considered that at this stage, without further evidence there was sufficient evidence, capable of proving paragraphs 7.a-h of the Allegation.

i. failed to provide any degree of reassurance to the family concerns or that you were acting in Patient D's best interests. To be determined

132. The Tribunal had regard to the wording of paragraph 7.i of the Allegation. It was alleged that Dr Nadal had failed to provide *any* degree of reassurance [Tribunal's emphasis] to Ms D during her phone conversations with him. The Tribunal had regard to the transcript and recording from the second telephone call from 28 February 2018. In the Tribunal's judgment there were instances in which Dr Nadal expressed some sympathy and sought to reassure Ms D. Furthermore, in that call, Ms D also told Dr Nadal *'Now I'm not anywhere near as cross as I was when I spoke to you earlier… I do feel a lot better. For that I thank you'*. Accordingly, the Tribunal concluded that there was insufficient evidence to prove that Dr Nadal had failed to provide *any* reassurance to Patient D's family. It determined there was no case to answer in respect of paragraph 7.i of the Allegation.

Conclusion

133. In conclusion the Tribunal determined there was no case to answer in respect of paragraphs 1, 2.e.iii, 4.d, 6.a.v, 6.c and 7.i of the Allegation. It concluded that there was a case for all of the remaining paragraphs.

134. The Tribunal therefore granted, in part, the 17(2)(g) application made on behalf of Dr Nadal.

ANNEX D – 26/07/2022
Adjournment

1. On 22 July 2022, a matter arose during the course of Dr Nadal's cross-examination. Following submissions on 25 July 2022, the Tribunal was informed that Mr Edis would not be continuing to represent Dr Nadal and that Dr Nadal's solicitors were seeking new counsel to represent Dr Nadal for the remainder of the hearing. In the circumstances, no further evidence was heard from Dr Nadal and Dr Nadal was released from his affirmation.

2. Without suitable representation, the Tribunal determined that it would not be fair to Dr Nadal for the hearing to proceed at this time. It is expected that the cross-examination of Dr Nadal will resume at a later date.

3. Today, 26 July 2022, the Tribunal, having determined that it would now be appropriate to adjourn the hearing to a future date, raised a number of case management matters with the parties.

4. The Tribunal was informed by Dr Nadal's solicitors that identifying suitable counsel for the currently listed September sitting days (14 to 22 September 2022) was proving difficult. In the circumstances, it determined that it would be appropriate to vacate the resumed substantive hearing dates listed to commence on 14 September 2022 and to re-list the case to 20 February 2023 for a further 15 days.

5. On behalf of the GMC, Ms Kitzing submitted that there may be a number of applications which the Tribunal is required to deal with ahead of Dr Nadal recommencing cross-examination. The Tribunal accepted this and determined to set aside two days of the current seven days listed in September to consider any applications in advance of the resumption of Dr Nadal's evidence. Dr Nadal's hearing will therefore reconvene on 15 and 16 September 2022 to hear legal argument only.

6. The Tribunal directs that skeleton arguments to support any applications to be heard when the hearing resumes be submitted by 1 September 2022. Any response is directed to be filed by 7 September 2022. Both arguments should then be provided to the MPTS to allow the Tribunal to consider written arguments at the earliest opportunity.

7. Further, the Tribunal directed that the parties could attend the case management hearing on 15 and 16 September 2022 remotely. However, the resumed substantive hearing would be in person with all parties to attend. If either party wished to attend the resumed substantive hearing remotely, an application would need to be made by 1 September 2022 and would be determined on 15 September 2022.

8. This hearing is therefore adjourned part heard. It will return to hear and determine any applications on 15 and 16 September and will then reconvene on 20 February until 10 March 2023 to continue these proceedings.

ANNEX E – 23/04/2023

XXX

ANNEX F – 19/07/2023

Application for Voluntary Erasure

1. This determination will be handed down in private. However, as this case concerns Dr Nadal's misconduct, a redacted version will be published at the close of the hearing.

2. Prior to the hearing reconvening on 18 July 2023, the Tribunal was informed Dr Nadal had made an application to the GMC for Voluntary Erasure (VE) on 7 July 2023 under the GMC (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations Order of Council 2004/2609 (VE Regulations).

3. The Registrar referred Dr Nadal's VE application to this Tribunal to determine.

Evidence

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

- Letter from DAC Beachcroft, Dr Nadal's Solicitors, in support of his application for VE, dated 7 July 2023;
- XXX;
- XXX;
- Letter from GMC confirming that Dr Nadal's application to relinquish his licence to practise had been granted, dated 30 June 2023;
- Letter from Dr Nadal's accountants confirming his financial position, dated 6 July 2023;
- Record of Determinations from Dr Nadal's Restoration Hearing following Administrative Erasure, dated March 2016 ('the 2016 Restoration Hearing');
- TIF Register Details from the Financial Conduct Authority, 12 July 2023;
- Dr Nadal's online application form for VE, dated 7 July 2023;

- Email from GMC confirming referral of Dr Nadal's application for VE to this Tribunal, dated 18 July 2023.

Submissions

On behalf of Dr Nadal

5. On behalf of Dr Nadal, Mr Geering set out the context in which Dr Nadal's application for VE was made.

6. XXX.

7. Mr Geering referred the Tribunal to the financial statement before it and submitted that Dr Nadal is a man of independent means for whom there is no imperative to work. Mr Geering submitted that there were clear reasons why Dr Nadal would not wish to work again. He reminded the Tribunal that Dr Nadal has considered himself retired since June 2022. Mr Geering submitted that it would not have been appropriate for an application for VE to be made at a prior stage of proceedings, whilst the determination of the Allegation was still outstanding. However, he submitted that the situation had now markedly changed. Mr Geering submitted that the facts found proved by the Tribunal had narrowed the scope of the concerns against Dr Nadal significantly.

8. Mr Geering submitted that it was for the Tribunal to consider whether it was in the public interest for Dr Nadal to leave the medical register before these regulatory proceedings have concluded. He submitted that the significant press attention in this case was not an indicator of the public interest. Mr Geering submitted that to grant Dr Nadal's VE application would not erase the factual findings that had been made against him. He submitted that to grant the application would significantly reduce the stress that the preparation for and participation in these proceedings have placed on Dr Nadal.

9. Mr Geering submitted that the determinations of the 2016 Restoration Hearing did not assist the Tribunal in its decision-making. He submitted that the circumstances were very different from the present application and did not demonstrate a pattern of behaviour whereby Dr Nadal would be erased from the medical register and then subsequently seek restoration. He submitted that whilst this hearing could conclude within the six days listed, it was possible that depending on the Tribunal's determinations, Dr Nadal could be subject to further hearings if a sanction was imposed in which a review was directed. Mr Geering

submitted that to have further proceedings hanging over Dr Nadal's head whilst enduring significant pressures in his personal life would be disproportionate.

10. Mr Geering accepted that the Tribunal had identified a serious failing in respect of Dr Nadal's decision-making in respect of not pursuing early aeromedical repatriation for Patient B. However, he submitted that the events occurred six years ago and the facts ultimately found proved were not so serious when compared to the Allegation that Dr Nadal had originally faced but had subsequently been found not proved. He submitted that the circumstances of the facts found proved did not require the hearing to continue in the public interest when balanced against the specific personal pressures and circumstances being experienced by Dr Nadal. Mr Geering invited the Tribunal to grant Dr Nadal's application for VE.

On behalf of the GMC

11. On behalf of the GMC, Ms Kitzing submitted that Dr Nadal's application for VE was opposed.

12. Ms Kitzing referred the Tribunal to the 2016 Restoration Hearing determination following Dr Nadal's administrative erasure from the medical register in 2016. She submitted that it was relevant that Dr Nadal had previously applied for restoration and would be able to do so again in the future if his application for VE was granted. Ms Kitzing accepted that, at any future restoration hearing, the GMC could revive the facts found proved by this Tribunal. However, she submitted that this Tribunal was best placed to determine issues of impairment and potentially sanction during these proceedings. Further, she submitted such a determination was proportionate and in the public interest.

13. Ms Kitzing submitted that the Tribunal's determination on the facts included serious findings regarding Dr Nadal's decision not to repatriate Patient B and also his communication with the families of Patient B and Patient D. Ms Kitzing submitted that it was of note that similar communication issues were raised at the 2016 Restoration Hearing.

14. XXX.

15. Ms Kitzing submitted that it was the GMC's position that the seriousness of the Tribunal's findings, and the significant public interest in this hearing being concluded outweighed Dr Nadal's interests. She submitted that to grant Dr Nadal's application for VE

would undermine public confidence in the medical profession and in the GMC and MPTS as regulators because serious findings have been made and should be fully and publicly ventilated by consideration of impairment and potentially sanction.

16. XXX. Ms Kitzing submitted that to grant Dr Nadal's application for VE at this stage would risk damaging public trust in the medical profession. Ms Kitzing submitted that the significant press and public interest in this case, including its reporting in a national newspaper increased the potential for harm to the reputation of the medical profession and its regulator if proceedings were not fully concluded.

17. Ms Kitzing submitted that there were no exceptional circumstances in this case to warrant Dr Nadal's application for VE being granted. She submitted that the facts found proved against Dr Nadal carried the presumption of impairment. If the Tribunal did not accept there was a presumption of impairment, Ms Kitzing submitted that there remained compelling public interest reasons to refuse Dr Nadal's application for VE.

The Tribunal's Approach

18. The Tribunal had regard to the *Guidance on making decisions on voluntary erasure applications and advising on administrative erasure* ('the VE Guidance').

19. The Tribunal conducted a balancing exercise, taking into account the interests of Dr Nadal and the public interest in considering his application for VE.

20. Throughout its deliberations, the Tribunal bore in the mind the need to uphold the overarching objective 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.

The Tribunal's Decision

21. The Tribunal first considered the circumstances, and reasons for, Dr Nadal making an application for VE.

22. The Tribunal had regard to the evidence provided on behalf of Dr Nadal. XXX. He is 74 years old and wishes to retire. His financial circumstances mean there is no financial imperative for him to return to work.

23. XXX.

24. The Tribunal accepted that Dr Nadal had legitimate reasons for seeking VE. It also accepted that Dr Nadal's current personal circumstances, his clear desire to remain retired and his financial independence meant it was highly unlikely that he would apply for restoration in the future. The Tribunal noted that in the online application for VE, Dr Nadal had indicated that he was *'unlikely'* to return to practise medicine in the UK. However, the Tribunal accepted that Dr Nadal had now made an *'irrevocable decision'* to seek VE as set out in a letter from his solicitors in support of his application, dated 7 July 2023.

25. Having accepted that there were legitimate reasons for Dr Nadal to wish to take VE, the Tribunal considered the overarching objective, including the public interest.

26. The Tribunal considered whether there would be a risk to public protection if it were to grant Dr Nadal's application for VE. It accepted that Dr Nadal has decided to retire and currently has no intention to seek restoration in the future. It accepted that he had relinquished his licence to practise. Further, it was reassured that, if Dr Nadal did apply for restoration in the future, he would not be restored without further enquiries being made as to his fitness to practise. There would be another restoration hearing where it would be open to the GMC to raise this Tribunal's findings of fact for further consideration as to the issue of impairment. The Tribunal concluded that it was unnecessary to refuse Dr Nadal's application for VE on grounds of public protection.

27. In considering the wider public interest, the need to maintain public confidence in the medical profession and to maintain professional standards and conduct for members of that profession, the Tribunal had regard to the seriousness of its factual findings.

28. The Tribunal had regard to paragraph 23 of the VE Guidance:

> *'23 The following are examples of cases where (except in exceptional circumstances) it will not be in the public interest to allow voluntary erasure or proceed with administrative erasure before the conclusion of fitness to practise proceedings, including a MPT hearing in some cases. This is because they involve a conviction for a*

serious criminal offence or the allegation carries a presumption of impaired fitness to practise.

a Ongoing police investigations or convictions for serious offences

Although it is not possible to provide an exhaustive list, the key issue is whether public confidence would be undermined if the GMC did not fully investigate the matter.

b Allegations of sexual assault or indecency

This encompasses a wide range of behaviour including allegations of sexual assault and abuse, allegations in relation to indecent images of children and allegations of sexual harassment in the workplace. This category also includes misconduct within a clinical setting where there is an allegation the doctor's behaviour was sexually motivated. For example, performing an intimate examination with no clinical justification or failing to maintain professional boundaries when treating a patient by making a remark of a sexual or inappropriate personal nature.

c Allegations of sexual or improper emotional relationships with a patient or someone close to them including that the doctor:

i behaved in a sexualised way towards a patient or someone close to them

ii pursued a sexual relationship with a patient or someone close to them, particularly but not exclusively where at the time of the professional relationship the patient was additionally vulnerable, for example due to their personal circumstances or mental health problems

iii abused their professional position by engaging in an inappropriate emotional or financial relationship with a patient or someone close to them.

d Allegations of violence

e Allegations of dishonesty

f Allegations of unlawful discrimination in relation to characteristics protected by law

g Allegations of knowingly practising without a licence

h Allegations of gross negligence or recklessness about a risk of serious harm to patients

The above is not an exhaustive list and there is clearly a public interest in allowing all allegations of serious misconduct to be fully investigated and, if there is a realistic prospect of establishing impairment, ventilated in public at a tribunal.*'*
[The Tribunal's emphasis]

29. The Tribunal accepted that its findings did not fall into any of the categories set out in paragraph 23 *a* to *g* of the VE Guidance. With regard to sub-paragraph *h*, the Tribunal accepted that *'gross negligence'* or *'recklessness'* had not been specifically alleged and no finding had been made by the Tribunal in this respect. However, the Tribunal considered that its findings, particularly in relation to Patient B, demonstrated significant and substantial failings by Dr Nadal, whether or not they could be characterised as being grossly negligent or reckless. Furthermore, as paragraph 23 makes clear, the examples listed are not intended to be exhaustive.

30. The Tribunal considered that the more serious the facts found proved the greater the public interest in considering the issue of fitness to practise and, if necessary, sanction.

31. In its facts determination, the Tribunal had, in respect of Patient B, identified a number of paragraphs of Good Medical Practice (2013) (GMP) that were engaged in this case. Most significantly, in respect of Patient B, who had died whilst in Turkey, it had found, as set out in paragraph 141 of its determination that:

'Dr Nadal had failed to pursue early aeromedical repatriation despite the evident need to do so. It determined Dr Nadal had failed because he did not take any meaningful action until 10 July 2017, by this time, as subsequent events were to prove, any opportunity that there may have been for a successful repatriation had been lost.'

32. The Tribunal also bore in mind that it had identified failings in respect of Dr Nadal's communications with the families of both Patient B and Patient D.

33. Having yet to commence the impairment stage, but being mindful of the seriousness of its factual findings, the Tribunal determined that there was a realistic prospect of establishing impairment by reason of misconduct. It considered that in the circumstances of this case it was appropriate for these issues to be ventilated in public with any determination being published after appropriate redactions had been made. The Tribunal did not consider that there were any exceptional circumstances which otherwise made VE appropriate.

34. The Tribunal did not accept that the submissions that the press interest in Dr Nadal's hearing of itself demonstrated that continuation of proceedings was in the public interest. However, in the Tribunal's judgment the seriousness of the case and the need to uphold the overarching objective required the hearing to continue to its conclusion.

35. The Tribunal considered that members of the public (which would include members of Patient B and Patient D's families) would be dismayed if the Tribunal failed to consider impairment in the light of its findings of fact.

36. It had been submitted on Dr Nadal's behalf that if proceedings continued, and a finding of impairment was made and a sanction imposed with a review directed, there was the possibility that Dr Nadal would have to face further MPTS proceedings which would cause additional ongoing stress. However, the Tribunal was not persuaded by this as a reason to grant VE. The Tribunal considered that in this eventuality, as was stated in the VE Guidance and accepted by the parties, it would be open to Dr Nadal to reapply for VE at any time after the substantive hearing had concluded.

37. In such circumstances, the Tribunal determined that Dr Nadal's application for VE should be refused in order to maintain public confidence in the medical profession and to uphold proper professional standards. It considered that it was proper for these proceedings be allowed to continue to ensure that the public confidence in both the profession and the regulator was upheld.

38. Accordingly, the Tribunal determined to refuse Dr Nadal's application for VE.