The problem surgical colleague

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'All doctors are problem doctors.' R Smith¹

ABSTRACT

The surgical profession, more than any other medical specialty, is constantly in the limelight. Frequently, concerns are expressed about our colleagues. The concerns may be personality clashes rather than failure in behaviour or performance.

Most concerns can be addressed locally with support from the Royal College Invited Review Mechanism of the National Clinical Assessment Service.

Unfortunately, if the concern is sufficiently serious or repetitive it may warrant referral to the General Medical Council (GMC) who alone has the right to withdraw a surgeon's medical registration. The surgeon will then be unable to work in the medical profession in this country.

The procedures the surgeon must undergo if referred to the GMC are stressful and protracted. Even if successful the surgeon will probably be expected to undergo a period of retraining that will prove difficult to arrange.

New proposals to modify the GMC procedures will reduce the standard of proof to one of 'balance of probabilities'.

The surgical profession should be accountable to its patients and colleagues. Will our Royal College rise to the challenge to establish itself as the bulwark of the surgical profession?

KEYWORDS

Employee difficulties – Low performance – Extended ill health – Behaviour

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The UK medical profession was shaken by the discovery that Harold Shipman murdered around 250 of his patients between 1971 and 1998.²

Although no-one is suggesting that The Royal College of Surgeons of England is harbouring a Shipman in their midst, nevertheless, many surgical departments have a consultant colleague about whom concerns have been expressed. Many concerns will be trivial and often can be linked to a misunderstanding that can be addressed successfully by an informal evaluation between a sympathetic Medical Director and the appropriate Clinical Director of Surgery.

In this article, I shall attempt to review the various procedures that are available when it is felt that a more formal investigation is warranted and how these different levels of disciplinary action inter-relate with each other.

Procedures

Local trust

The increase in the number of consultants referred to the National Clinical Advisory Service (NCAS) and General

Medical Council (GMC) has prompted the Department of Health to encourage more cases to be handled initially by individual trusts.³

If an employee of the trust has a concern about a surgeon or should a patient or relative raise a concern with an employee then that employee should report this to their line manager. The line manager should then report the concern to the Medical Director or Chief Executive. There are three separate concerns:

MISCONDUCT OR BEHAVIOUR

This would include the wilful, careless or inappropriate behaviour likely to compromise standards of patient care or safety; or a failure to fulfil a contractual obligation. Put simply, one could be an outstanding operator but would be misbehaving if one went round the operating theatres punching the staff.

CAPABILITY OR PERFORMANCE

This would include the use of out-of-date or incompetent clinical practise and inappropriate clinical practise arising from lack of knowledge or skill. Again, put simply, one

could be a perfect gentleman in the theatre suite but have an unacceptably high operative complication rate.

ILL HEALTH

This covers the situation where a surgeon is off sick for more than 4 weeks and there is no anticipated date for his or her return. Also, where issues of performance or behaviour are felt to have arisen solely as a result of ill health on the part of the surgeon.

Once a complaint has been received by the Chief Executive or Medical Director, they will appoint a Case Manager. The Case Manager will generally be the Medical Director, if the case refers to a consultant, or the appropriate Clinical Director. However, for a surgeon in a training grade, if the Case Manager has had prior involvement in the issues, another Clinical or Medical Director, as appropriate, from the trust or another trust.

The Case Manager should conduct a preliminary investigation by interviewing the key witnesses and reviewing the medical records. It is expected that within 5 working days the Case Manager should be in a position to decide if there is a serious concern requiring restriction on, or exclusion from, practise of the surgeon. Alternatively, the Case Manager may regard the matter as less serious and could agree a NCAS clinical assessment, or approach The Royal College of Surgeons of England and invite a review by the Invited Review Mechanism (IRM), formerly the Rapid Response and Service Review Mechanisms. In the case where the concern is regarded as minor, informal counselling or an oral reprimand may be all that is necessary for the surgeon to grasp the nature of the concern.

If the Case Manager considers a formal investigation is needed then a Case Investigator is appointed by the Chief Executive and Director of Human Resources and will usually be a senior member of the Department of Human Resources assisted by a senior surgeon working in the same specialty. The Case Investigator will be expected to address the concerns, which were the subject of the investigation, but is not limited to this and can widen the range of the enquiry to include additional patients or incidents, if appropriate. If it has been decided to investigate a surgeon formally, he or she must be told that:

- There will be an investigation
- The specific allegations
- The name of the Case Investigator and Surgical Advisor
- Who will be interviewed
- The surgeon's right to meet the Clinical Investigator and put forward his or her views.

The Case Investigator has wide discretion as to how to carry out the investigation. The Clinical Advisor should not have been involved directly in the issue to be investigated. The report by the Case Investigator should include the

background to the investigation, and what investigations were undertaken, *e.g.* nurses and surgical colleagues who were interviewed, and medical records that were scrutinised. The report must include the main factual evidence that was obtained and provide a preliminary view as to the soundness of the case against the surgeon. In addition, the surgeon has 10 days to respond to the factual points of the report.

The Case Investigator's report will then be reviewed by the Case Manager (who will be the Medical Director or an Assistant). The report should provide enough evidence for the Case Manager to decide if:

1. There is a case of misconduct (misbehaviour).
2. There is a case of lack of capability (poor performance).

If either apply, there should be consideration if the case can be handled locally, or whether the surgeon should be referred to the NCAS, or even GMC. Whether any restriction should be placed on his or her practise, or even exclusion from work.

3. There are concerns about the surgeon's health, which will be addressed by the Occupational Health Department.
4. No further action is necessary.

A surgeon can be excluded, but not suspended, by this local process. Further exclusion should only be a last resort if other actions are felt to be insufficient, including:

- A voluntary undertaking to restrict his or her practise
- Working under direct supervision of the Clinical Director
- Restricting some clinical duties
- Restriction of all clinical duties.

The local management team should discuss any decision to exclude their surgeon with the NCAS, and initially the exclusion can be for only 2 weeks. A longer or formal exclusion should only occur where there is a need to protect patients or staff. Exclusion from trust property is only necessary if it is felt that the surgeon will tamper with evidence or seek to influence colleagues; where possible, the surgeon should be allowed onto trust property for continuing professional development (CPD). For instance, the exclusion order could exclude the Postgraduate Centre.

The NCAS can recommend that any local recommendations should extend beyond the trust to the private and voluntary sectors. Any exclusions should be reviewed every 4 weeks; after 3 months, if not resolved, the trust must formally refer the matter to the NCAS and Strategic Health Authority (SHA).

A referral to the GMC is extremely serious and could result in withdrawal of a surgeon's licence to practise medicine. It is hoped that a surgeon would not be referred to the GMC unless he or she breaches any undertaking given to the Case Manager or where there are serious allegations affecting patient safety.

If the Case Manager believes there should be a formal hearing to decide if there has been an error of behaviour or

performance, the surgeon and his or her representatives must be notified of the hearing and given sufficient time to consider their case. Both sides must exchange written documents and witness statements that they will use as evidence at least 5 days before the hearing. The Case Manager will present the management case.

The panel will consist of an Executive Director of the trust, a medical practitioner, not employed by the trust, a trust board member and a senior clinician from the same surgical specialty, but from another trust. There are strict guidelines on the order and protocol to be observed by both sides when presenting their evidence and cross-examining each other's witnesses. The panel will consider its decision, which could be:

- No action
- Verbal warning
- First written warning
- Final written warning
- Demotion, or transfer to an alternative post
- Dismissal.

In tune with natural justice, there is an appeal procedure, if the surgeon believes the disciplinary panel did not act fairly or reasonably. The surgeon must appeal within 25 days to the trust's Director of Human Resources.

The appeals panel is similar in structure to the disciplinary panel, but no member of the disciplinary panel may sit on the appeals panel. The appeals panel has access to the documents from the disciplinary hearing and the surgeon may present additional evidence and witnesses. The Case Manager will present the management case. The appeals panel may:

- Confirm the decision of the disciplinary panel
- Amend the decision
- Order the case to be reheard in its entirety.

Invited Review Mechanism (IRM)

The Royal College of Surgeons of England and the Surgical Specialist Associations established the IRM in 1999. The IRM is intended to support, but not replace, the existing local procedures for dealing with individual surgical performance issues. The review is initiated by a request from the Medical Director or Chief Executive of the trust. Both the surgeon and trust must agree to the exercise taking place. The trust must meet the cost of the review and agree to indemnify the College, the Specialist Association and the reviewers.

The IRM will normally be comprised of two surgeons who are working in a similar environment to the surgeon under investigation. One is nominated by the College and one by the relevant Specialist Association. The surgeon under review can object to any of the reviewers, but only in exceptional circumstances will the reviewers be altered.

Once the terms of reference for the review have been agreed, the trust will contact the reviewers directly to make the necessary administrative arrangements for the review. The Medical Director must make available all relevant documentation relating to the terms of reference for the review and the questions the reviewers are asked to consider. The reviewers will have the opportunity to request from the trust or surgeon additional information they believe is necessary.

Reviewers will normally address issues strictly within the terms of reference. If asked to address concerns about a consultant's cataract surgery, they would not investigate his or her corneal surgery. Similarly, if there are concerns about endoscopic surgery, they will not enquire about open surgery. The visits generally take 1 or 2 days. The IRM differs from the NCAS and GMC in that it is not providing a full assessment of the surgeon's practise.

The surgeon should have an opportunity to reflect on those members of staff who are to see the reviewers. The surgeon has the right to request additional members of the clinical team to be part of the review.

The reviewers will meet the surgeon at the beginning of the process to ensure the surgeon has the opportunity to present his or her view. There will be a second meeting at the end of the visit when the reviewers can appraise the surgeon of their preliminary findings and possible recommendations that might be made to the trust. The surgeon has the right to respond at this stage.

The reviewers will generally review audited operative data or case notes and interview members of the clinical team. It would be unusual for the reviewers to conduct clinical examination but, if so, the hospital must ensure the patients are fully informed.

A draft report is prepared by the College and sent to the trust and surgeons to check for factual accuracies. The formal report is forwarded to the trust as soon as possible and usually within 3 months.

The IRM report is advisory and their recommendations are for consideration by the trust, which is entirely responsible for any decision or subsequent action. However, the reviewers can make recommendation for re-familiarisation of an operative procedure, in a separate unit, or a period of further training. Finally, the reviewers can refer the surgeon to a regulatory body, the GMC, if they feel that this would be in the interest of the general public.

The cost to the trust for a IRM is about £10,000.

National Clinical Assessment Service (NCAS)

The NCAS⁴ has taken over the role of the National Clinical Assessment Authority (NCAA), that was established as a special health authority in April, 2001. The NCAA was established in response to recommendations by the Chief Medical Officer *Supporting Doctors, Protecting Patients*, November, 1999 and

Assuring the Quality of Medical Practise: Implementing Supporting Doctors, Protecting Patients, January, 2001.⁵

NCAS recognises that there are a variety of contributory factors influencing under-performance. These include poor health, disability compounded by the fact that, as a group, surgeons are reluctant to admit to illness and their colleagues may collude in this. Also mental health – surgeons experience levels of stress, higher than average for British workers. There maybe underlying personality problems, or the trust or department may be a dysfunctional organisation or culture. Other factors that can adversely effect a surgeon's performance include workload, sleep loss due to shift working, and working in an ineffective team.

The Chief Executive or Medical Director can contact the NCAS by telephone 'helpline' and will be able to discuss the problem with a case worker who will take the essential details. It is wise to contact the helpline at an early stage when problems arise and there is no cost to the trust. They will then pass the case to a NCAS adviser who will be a senior medical practitioner. The adviser will speak with the Chief Executive or Medical Director and may:

1. Offer general advice.
2. Provide more detailed support to the Local Trust Procedures (see above).

Local, case-management support is a more intensive involvement, which may include case conferences with the trust and surgeon. The NCAS role is to support the local parties by facilitating meetings and offering an independent and fresh perspective. However, if the trust considers a full assessment of a surgeon's practise is required, then the matter should be taken over by the NCAS to avoid the possibility of 'double jeopardy' for the surgeon.

3. Undertake an assessment of the surgeon's practise. This will occur when the concerns are serious or repetitive and have not been amenable to local resolution. This is an intense and expensive process. The NCAS Case Manager and adviser, the surgeon and trust senior manager will meet to agree the process which has three components.
 - i Occupational Health Assessment by an occupational health physician. This is to identify any health or work environmental factors that may be contributing to the surgeon's difficulties.
 - ii Behavioural assessment by an occupational psychologist. This takes 2 days and involves an 8-hour clinical assessment questionnaire and an interview. This evaluates the surgeon's personal attributes and considers how these may be shaping their behaviour at work.
 - iii Clinical assessment in the trust. This may last 3 days with a panel consisting of a lay chairperson, two surgeons within the specialty and a general practitioner.

The clinical performance is assessed with reference to good medical practise guidelines set by the GMC⁶ and any

College guidelines. Good medical practise was revised in November, 2006. The clinical assessment will include an interview with the surgeon and a senior representative of the trust. There is a review of 50 sets of medical records. The panel interviews colleagues, usually 10 nominated by the trust and 10 by the surgeon. The panel will observe the surgeon in clinics, but not operating. The panel may write to up to 50 patients, chosen by the trust, who have been under the care of the surgeon. Finally, there is a wide-ranging interview involving clinical topics.

The assessment report is then drawn up that includes recommendations for the trust and surgeon. If re-training is needed, this will have to be arranged through the Postgraduate Deans and College. The trust is responsible for implementing any recommendations and for ensuring that the arrangements for signing off the completion of the re-training programme have been fulfilled. The cost to the trust of a NCAS assessment is £30,000.

General Medical Council (GMC)

The GMC⁷ was established under the *Medical Act* of 1858. The aim was to standardise undergraduate medical education and licence doctors in practise. If a surgeon has his or her licence withdrawn, they cannot practise within the UK. In 2005, there were 4980 referrals to the GMC.

The GMC is a professionally lead regulation in partnership with the public. The values it espouses in a doctor are embodied in its publication *Good Medical Practise*.⁶

A member of the public, a patient, a professional colleague, a NHS trust or private hospital and NCAS may refer a surgeon to the GMC. The GMC has the power to issue a formal warning, remove a doctor from the register, and suspend or place conditions on a doctor's registration.

When a surgeon is referred to the GMC, a Case Manager will undertake an initial investigation. This may include a discussion with the surgeon's employer (Trust Chief Executive or Medical Director). In addition, witness statements and expert reports can be obtained. At the end of this initial investigation by the GMC, the evidence will be considered by two case examiners (one medical and one lay member). They can:

- Conclude the case with no further action
- Arrange for the surgeon to be assessed by a Panel of Assessors (the Assessors) appointed by the GMC
- Refer the case directly to a Fitness to Practise Panel

The assessment

If the GMC believes action may be appropriate, the next stage is usually an assessment (about 70 doctors have a performance assessment each year). The GMC will arrange for a committee of usually three to visit the surgeon at his or

her hospital. The committee will comprise a lay member and a surgeon, both of whom will have gone through the GMC assessment training procedure.⁸ The surgeon will be from a specialty closely allied to that of the surgeon undergoing the assessment. In those smaller specialties (*e.g.* transplantation), if there is no GMC trained surgeon available, a fourth panellist will be appointed from the specialty. The chairman is medically qualified and will have substantial experience of GMC practise procedures, indeed may be a full-time employee of the GMC.

The assessment is a harrowing 3-day ordeal for the surgeon under review.⁹ The surgeon is asked for a portfolio in which he or she describes their education and training, details of current clinical practise, continuing medical education, clinical audit and a personal evaluation of their clinical and communication skills.

Medical record keeping

The assessors review 50 sets of case notes to evaluate their clarity and logic (how many consultant surgeons keep their patients medical records up-to-date?).

Case-based discussion

There is a case-based oral discussion in which the surgeon discusses 12 of his or her own cases with the medical assessors.¹⁰ Each assessor will be documenting their judgements against criteria of acceptable, cause for concern or unacceptable.

Site tour

There is a tour of the hospital to evaluate the surgeon's working environment and his or her familiarity with the facilities and equipment they claim to use regularly.

Third party interviews (TPIs)

Twelve interviews with those who regularly work with the surgeon. The surgeon is entitled to name five to be interviewed (and would be strongly advised to do so). Those interviewed are likely to include surgical colleagues, the ward sister and operating theatre sister. All interviewees are asked the same questions, which are preset and standard. The witnesses are not questioned under oath, nor are they cross-examined. Because of the subjective nature of TPI, they are given less weight than the more objective assessments.

Final interview

The assessment panel meet the surgeon for a final interview to clarify any outstanding matters and to give the surgeon an opportunity to present any information he or she wishes.

Tests of competence

The GMC worked with the College to develop these assessments.¹¹ In each case, the surgeon completes a written

knowledge test, is observed performing an interview with a simulated patient and demonstrates practical skills in a surgical-skills workshop.

The testing of competence generally occurs a few days after the previous evaluation away from the surgeon's work-place. The skills' tests have been performed at the surgical skills centre in Sheffield, but the GMC plans to hold them also at its centre in Regent's Place, London.

The skills' tests are constructed as an objective, structured clinical examination (OSCE). The surgeon is asked to perform a series of tests such as scrubbing up, preparing a mannequin for a named operation, performing a bowel anastomosis. It is important to remember that the surgeon undergoing this skills' test may well have been suspended by his or her trust for 12 months by the time they undergo this test. The evaluation is performed by the same assessors who undertook the earlier interviews.

The performance of the surgeon is scored and then compared to that of a group of volunteer surgeons of comparable experience and from the same specialty who have been invited to undertake the test previously. Again, the surgeon's performance is graded as acceptable, cause for concern, or unacceptable.

Following completion of the assessments, the lead assessor writes a report for the GMC case co-ordinator and the committee on professional performance. This report compares the surgeon's performance with the standards of good medical practise. Both strengths, weaknesses and the hospital's working conditions are taken into account. The assessors weigh the evidence and reach a judgement based on triangulation. Triangulation is the principle whereby information from three separate sources suggests a similar conclusion. For instance, if in a third-party interview, the theatre sister suggests there is a high rate of complications, the case-note review also points to a high complication rate and the surgical skills' test raises concerns, then there are three separate pieces of evidence suggesting a problem of surgical technique.

The assessment panel will forward the report to the GMC who may conclude that the evidence gathered does not warrant further action and the surgeon is able to return to his or her working practise.

The GMC may conclude that remedial action may correct the problem. The assessors' report will be made available to the surgeon who can use it to plan a programme of remedial activity.¹² Advice can be sought from the regional Postgraduate Dean and, subsequently, a further re-assessment made; if the performance has improved, the case is concluded.

Finally, the GMC may decide to refer the surgeon to a Fitness to Practise Panel. This panel has the authority to: (i) impose conditions on the surgeon's registration; (ii) suspend the surgeon's registration; or (iii) direct that the surgeon's name is erased from the Register.

It may take up to 6 months from referral to the Fitness to Practise Panel until the case is held. These cases are conducted in the GMC offices in London and Manchester. The Fitness to Practise Panel usually comprises of five Associates. At least one panellist is medically qualified and at least one lay person. The chair may be a lay person or medically qualified and, if the surgeon is from an ethnic minority, one of the medical panellists must be from a similar ethnic minority.

In addition to the Panel, there is a medical adviser from the same surgical specialty, and a legal adviser. There is a shorthand writer to take a verbatim note of the proceedings. The hearings are usually held in public.

The surgeon is invited to attend and may be legally represented. He or she is advised to do so, even if admitting responsibility, but to plead mitigating circumstances. About 10 days before the hearing, the agenda and papers are sent to each party. This often seems little notice and a delay may be requested.

The GMC's legal representative (Presenting Officer) presents the GMC's case and may call witnesses to give evidence on oath. These witnesses may be cross-examined by the surgeon's legal representative. The Panel may also ask questions. The evidence the GMC will present is largely based on the findings at the earlier site visit, and results of the clinical questions and surgical skills' test.

When the GMC has concluded its case, the surgeon, or his/her representative, presents their case. The surgeon may give evidence and call witnesses. The Presenting Officer may cross-examine them and the Panel may ask questions, as may the specialty adviser.

Once the Panel has heard the evidence and final submissions, it will retire to consider its verdict. At present, the Panel makes its decision based on the standard expected in a criminal court, that the case against the surgeon must be proved by the GMC to be 'beyond reasonable doubt'. The Panel announces its decision in public. Assuming that some of the facts have been proved, the Panel will then consider further evidence and submissions on whether the surgeon's fitness to practise is impaired, and what sanctions to impose on the surgeon's registration (see above). The process from referral by the trust of the complaint to the GMC judgement will have taken at least 12 months and often substantially longer. During this process, the surgeon will have been suspended. Indeed, it would be hard to continue to work whilst under such stress. The Panel will almost always recommend a period of re-training even if there are no restrictions applied to the registration.

Unfortunately, the surgeon will usually have difficulty arranging an appropriate re-training programme with his or her Postgraduate Dean, who is under no obligation to set up such a programme. Neither are any group of surgeons or trust under any obligation to offer suitable re-training for a

surgeon who has gone through the GMC Fitness to Practise procedure.

The surgeon has a right to appeal to the High Court (Court of Session in Scotland) in any case where the Panel take action affecting the surgeon's registration.

Comments

The procedures for dealing with a problem surgeon are multiple and stressful. Some competent surgeons have been put through this process due to personality clashes without there being clear evidence of poor or indifferent practise.

A surgeon can be subjected to the local procedures supported by the College IRM and found to be competent. Nevertheless, the trust board remains free to refer the case to the NCAS if it is unhappy with the judgement. If the trust is unhappy with the NCAS report, the surgeon can still be referred to the GMC. This exposes the surgeon not only to double jeopardy but even triple jeopardy. The trust board would argue that, where there is concern about a surgeon's competence, they must pursue every avenue to protect patients and maintain the highest standard of clinical governance.

It has always been a central tenet of the justice system that criminal charges must be proved beyond all reasonable doubt, *i.e.* 95% certain rather than on the balance of probabilities (*i.e.* 51%). The criminal standard of proof has operated in cases before the GMC because the ultimate sanction is withdrawal of registration. Erasure from the medical register has a profound and lasting impact on a surgeon, which will generally result in the end of his or her career and livelihood.

Following the Shipman inquiry's fifth report,¹⁵ a review of the GMC was recently completed by Sir Liam Donaldson.¹⁴ In this review, it was suggested that level of proof should be based on that used in the civil court which is based on the balance of probabilities and a majority decision of the panel members.

At present, there are a huge number of complaints made about doctors. In 2005, the GMC alone received 4980. It is proposed¹⁴ that more of these complaints could be dealt with locally and even arrange for locally respected surgeons, trained, funded and supported, to investigate and, when appropriate, resolve concerns although it is unclear if many surgeons would wish to take on such a role.

In a Fitness to Practise case, brought by the GMC against a surgeon, the GMC presents its own case. The jury is composed of GMC appointees and the same GMC panel delivers the judgement. The GMC acts as prosecutor, jury and judge. Possibly, in due course, the GMC will only undertake the investigation and assessment.¹⁴

The present tiers of judgement are probably largely ignored by the truly problem surgeons, whilst the threat of discipline needlessly worries the good surgeons. However, potentially, we are all problem surgeons. And, even if we are

not problem surgeons today, we might be tomorrow. Who wants to criticise a colleague in such circumstances?

We understand how they grapple with the most awful difficulties with limited means, and we do not want to condemn them.¹ Nevertheless, a profession is one that determines its own standards and sets its own examinations. It is self-regulating and is accountable to its clients and to the profession itself.¹⁵

Perhaps the College will rise to the challenge to re-establish itself as the bulwark of the surgical profession.

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