Comment: ‘The problem surgical colleague’

The review of ‘The problem surgical colleague’ by Mr John Mosley is both timely and relevant. All surgeons are naturally concerned about the mechanisms in place, both locally and through the General Medical Council (GMC) to deal with fitness-to-practise issues. It is inevitable that criticisms, often unfounded, are voiced by the profession. Most surgeons welcome a fair and transparent system to deal with such matters whilst maintaining the principle of self-regulation. We must accept that there are a small number of surgeons whose practice is impaired to such a degree that they represent a serious patient-safety risk and they must be dealt with appropriately.

As a GMC medical case examiner since 2003, and having dealt with over 600 fitness-to-practise cases, I wish to comment on some of the important issues raised by Mr Mosley, specifically in relation to the surgeon and his or her practice. In doing so, I will set out the investigative process to be followed when fitness-to-practise concerns are brought to the attention of the GMC.

The investigation stage

Information concerning a surgeon’s fitness to practise may be received from a complainant or a person acting in a public capacity, or may otherwise come to the attention of the GMC.

The complaint is assessed by a Registrar to determine whether or not it gives rise to an allegation of impairment. Under the *Medical Act* (1983), impairment can be by reason of any or all of the following:

- *Misconduct*
- *Deficient performance*
- *A criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England and Wales)*
- *Physical or mental ill-health*
- *A determination by a regulatory body either in the British Isles or overseas.*

This initial assessment process is called ‘triage’ and many complaints can be appropriately concluded at this stage. Cases which pass this initial sift are dealt with through an investigation process, which always involves informing the surgeon and writing to the surgeon’s employers for any background information.

The Investigation Manager will assign an Investigation Officer to the case and that person may contact the Medical Case Examiner for advice generally, or more specifically, for decisions in the following areas.

Interim Orders Panel (IOP)

The Medical Case Examiner is also called upon to decide whether a matter should be referred to the Interim Orders Panel (IOP).

Referrals to IOP may occur where the surgeon faces allegations of such a nature that it may be necessary for the

protection of members of the public or otherwise in the public interest, or in the interest of the surgeon, for the surgeon’s registration to be restricted whilst the allegations are being investigated.

As far as surgeons are concerned, examples of referrals to IOP may include repeated series of surgical failures such that there is a concern relating to the proper standard of care or a serious lack of basic medical knowledge or skills. A further example would be where a surgeon repeatedly undertakes procedures beyond their level of competence.

IOP is a rapid mechanism designed to protect members of the public with a view to making an order suspending or imposing conditions on a surgeon’s registration for periods up to 18 months.

Performance Assessments

The Medical Case Examiner is required to make the decision as to whether surgeons should be subject to a ‘Performance Assessment’. The kinds of concern that may trigger a Performance Assessment include:

- A tendency to use inappropriate or outdated techniques
- A basic lack of knowledge/poor judgement
- A lack of familiarity with basic clinical/administrative procedures
- Poor record keeping or failure to keep up-to-date records
- Poor prescribing.

Similarly, a ‘Health Assessment’ process can be invoked where it is alleged that a surgeon’s fitness to practise is impaired on grounds of health.

Mr Mosley has comprehensively dealt with the subject of Performance Assessments and so I will focus on what happens at the conclusion of the assessment process.

In situations where the surgeon's fitness to practise has been called into question as a result of evidence gathered following an assessment, the Case Examiners will need to consider whether disposal by way of undertakings might be sufficient for the protection of patients. The Case Examiners need to decide whether the surgeon is: (i) not fit to practice; (ii) not fit to practice except on a limited basis or under supervision, or both; or (iii) following a health assessment, suffers from a continuing or episodic physical or mental condition which may be expected to cause a recurrence or impairment of the surgeon's fitness to practise.

If the Case Examiners decide that the doctor is not fit to practice or only fit to practice on a limited basis or under supervision, they must consider whether there is a realistic prospect of the doctor being erased and if so, must refer to the fitness to practise panel for adjudication.

Conclusion of the investigation

At the conclusion of the investigation, two Case Examiners, one medical and one lay, are called upon to make a decision. The decision may be to conclude the matter (the majority), to issue a warning, to issue undertakings or to refer to a Fitness to Practise Panel. Case Examiners may also decide to write a letter of advice to the surgeon if appropriate. In the vast majority of cases, both Case Examiners agree on the proper course of action in relation to the investigation. However, where there is no agreement, the matter will pass to the Investigation Committee to make a decision.

The test to be applied by the Case Examiner once they have considered the underlying allegation, and often voluminous evidence obtained during the investigation (often including the relevant medical notes) is the 'realistic prospect test'. In doing so, 'the Case Examiners must have in mind the GMC's duty to act in the public's interest, which

includes the protection of patients and maintaining public confidence in the profession in considering whether there is a realistic prospect of establishing that a doctor's fitness to practice is impaired to a degree justifying action on registration'.

The realistic prospect test applies to both the factual allegations and to the question of whether, if established, the facts would demonstrate that the practitioner's fitness to practise is impaired to a degree justifying action on registration. It reflects not a probability but rather a genuine possibility. In deciding on the realistic prospect test, the Case Examiners are entitled to assess the weight of evidence but should not normally seek to resolve substantial conflicts of evidence. In considering whether to issue a warning, the standard of proof is the civil standard, *i.e.* on the balance of probabilities.

This comprehensive investigation process is designed to provide a fair and transparent means of dealing with an allegation and deciding whether there is indeed a realistic prospect of action being taken on the surgeon's fitness to practice.

Conclusions

It is accepted that regulatory methods to deal with fitness-to-practice issues will not be popular and are inevitably criticised by all parties. Nevertheless, such mechanisms are essential to deal with the problem surgeon – happily very few in number. In my view, the present processes are fair, transparent and effective.

Acknowledgement

I am grateful to Jackie Smith, GMC Fitness to Practise Directorate, for providing helpful comments.

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