The Surgical Forum of Great Britain and Ireland
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'Managing the surgeon in difficulty'

Foreword

The Surgical Forum of Great Britain and Ireland, formerly known as the Senate of Surgery, is comprised of the Presidents and Vice Presidents of the four Royal Colleges and the Presidents of the 10 SAC-defined and GMC-recognised surgical specialties. The Surgical Forum is therefore a truly representative voice of surgery across the entirety of Great Britain and Ireland.

In recent years the Surgical Forum meetings have all followed a similar format: a topic is selected that is important across both the specialty spectrum as well as having relevance to all geographic parts of the UK and Ireland and, as such, is relevant to all four Colleges. Each meeting is for a full day, is prefaced by invited guest speakers to lay the groundwork to the subject and then all members of the Forum are invited to contribute to the discussions. The proceedings of the meetings are described in a discussion paper which is agreed by all participants prior to being posted on SSA and College web sites and being made available to the media.

The topic of the most recent Forum meeting was '*How to deal with the surgeon in difficulty*'. This meeting was held at the Royal College of Surgeons of Edinburgh on Thursday 12th March 2015. An attendance list and programme showing names of invited speakers and their representative organisations are attached as Appendix 1. In addition to the Presidents, or their representatives, of the four Royal Colleges and 10 Specialty Associations, BOTA and ASIT were represented, as was the English College Patient Liaison Group.

This document aims to provide a consensus view. It is based upon the opinions expressed throughout the meeting. Preliminary drafts were distributed to all participants as well as to other interested parties in surgery. This document is therefore a representation of the opinion of the surgical profession throughout the UK and Ireland.

Summary

- Surgeons run into difficulties because of ineptitude rather than ignorance. It is important to distinguish between conduct issues and those relating to capability.

- The numbers of surgeons 'in difficulty' is increasing. However, the problem is actually relatively small in the context of the total number of surgeons in practice, although the impact on patients, the individual, their local professional community, the organisation they work for and wider public trust is potentially catastrophic.

- There is no evidence to confirm that surgeon-specific outcome data is a reliable and robust means of identifying the surgeon in difficulty.

- The complexities of managing a surgeon in difficulty mean that it is theoretically possible that the individual under investigation could have their circumstances being considered by an RCS IRM, NCAS, a local Trust investigation and the GMC.

- The best advice to surgeons to avoid getting into difficulty is to have insight and work as an integral part of a multidisciplinary team.

- There were many adverse comments expressed about the perceived role of GMC, as sole regulator, and the way it approaches its fitness to practise activity.

- Recommendations for the management of the surgeon in difficulty are defined. These include avoidance of unrealistic objectives, inappropriate removal from the workplace and the benefits of early third party advice.

1. BACKGROUND

There are almost 250,000 doctors registered in the UK and Ireland. Their duties and responsibilities are clearly defined in publications such as *Good Medical Practice* published by the UK's sole regulator of the medical profession, the General Medical Council[1]. There are approximately 15,000 practicing surgeons in the UK and Ireland. They, as registered doctors, must practice in accordance with GMC guidelines. In addition the Surgical Colleges have produced specific recommendations for the practice of surgery, e.g. *Good Surgical Practice*, published by RCS Eng 2014[2].

Documents such as *Good Surgical Practice* aim to provide a baseline of clear standards for individual surgeons to demonstrate within their practice. They are not statutory codes. They seek to exemplify the standards required of all doctors by the GMC in the context of surgery.

There is increasing recognition that surgery is not a solitary activity. Patient safety and good practice depends not only on individual surgeons but also on effective team working both within the surgical team as well as the wider multidisciplinary team. There is also a need for surgeons to be seen to have effective relationships with both their clinical and non-clinical managers and for them to demonstrate leadership for the benefit of patient care.

Notwithstanding the above, there is remarkably little in the medical literature appertaining to the optimal means by which a 'failing' doctor or surgeon might be identified and what represents best practice in terms of the management of such an individual. Such an absence of consensus must be one factor that has led to the plethora of organisations having a part to play in the management of the failing doctor: these include the GMC, NCAS, the Deaneries, individual Trust HR departments and Medical Directors, Colleges and Specialty Associations. Not infrequently, doctors considered to be performing below standard or unsafely may find themselves the subject of investigation from more than one organisation at any one time.

There are many possible reasons why surgeons may find themselves in difficulty. These include:

- Problems with their clinical competence
- Problems arising from their behaviour
- Problems caused by relationships with colleagues
- Problems resulting from their communication with patients
- Problems with their health.

Other wider issues affecting healthcare may also have affected these circumstances, for example:

- Abbreviated training processes providing limited practical surgical experience
- Contemporary NHS non-clinical managers may have limited insight into the complexity of surgical practice, and in consequence be unable to distinguish between unacceptable and acceptable surgical outcomes
- The complexity of modern NHS structures and the way these interface with patients who have greater expectations
- The politically motivated 'blame and shame' culture within the NHS
- A 'target mentality' eroding professional independence
- Increased numbers of surgeons having qualified outside the UK may lead to challenges when adapting to the UK NHS working environment and cultural expectations from both colleagues and patients
- Erosion of the surgical 'firm' which engendered a team approach to care

- A lack of incentives to inspire high quality performance; there should be incentives to reward good teams and good leadership and not only individual awards such as exist at present
- The new consultant contract and EWTD which emphasise and reward time worked to the detriment of flexibility and professionalism.

Whilst there is no doubt that some or all of these factors may be contributory factors in individual cases, the reality is that robust evidence to support any of the above is lacking. This must explain, to some extent, the lack of a consistent approach to the problem of the surgeon in difficulty.

Perhaps we need a fresh approach. The philosophers Gorovitz and MacIntyre wrote an essay in 1976 on the nature of human fallibility[3]. What they wondered was why do human beings fail at anything that we set out to do. They suggested that there are two primary reasons for failure: firstly, ignorance. We have only a limited understanding of all of the relevant physical laws and conditions that apply to any given problem or circumstance. And secondly ineptitude, meaning that the knowledge exists but an individual or a group of individuals fail to apply that knowledge correctly.

Such are the stringencies of College examinations and the requirements of consultant certification, it is unlikely, albeit not impossible, that ignorance (capability) is a regularly recurring factor in surgeons getting into difficulty, particularly if they have been in established consultant practice for some time. That having been said, it is possible for a consultant to become complacent with regard to keeping apace of the rapid rate of development of medical and surgical practice, and the verification of the effectiveness of CPD activity within the appraisal process which underpins revalidation is rudimentary.

Nonetheless it is more likely that surgeons get into difficulty because of ineptitude (conduct). This might be a failure of individual practice, team working, a manifestation of working outside one's area of expertise, social or health problems, or a breakdown of acceptable working practices in their place of work.

The surgical profession should lead the initiative with regards to the management of the surgeon in difficulty. The media loves the 'botched surgery' story. We must endeavour to avoid such public demeaning of our profession. To do this will necessitate even greater transparency. This raises the contentious issue of reporting surgeon outcome measures, but also serves to focus the need for surgeons to consider other means of appearing 'transparent' such as audiotapes and video recorders. As Atul Gawande said in a recent Reith lecture[4], *'We have no black box for what happens in our operating rooms or in our clinics. The data when we have it is often locked up. You can't know, even though we have the information, which hospitals have a better complication rate in certain kinds of operations than others. There's a fear of misuse, a fear of injustice in doing it, in exposing it'.*

Finally, by way of background it is perhaps useful to have a definition of professional performance:

'The professional performance of doctors represents the successful deployment of a range of factors that include elements related to the individual such as health (all aspects physical and mental including cognition), personality and the possession of sufficient clinical knowledge and skills; elements related to the workplace such as leadership, climate, culture and team dynamics and elements related to education from medical school selection through the undergraduate curriculum to the ability to maintain and improve performance by way of continuing professional development'[5].

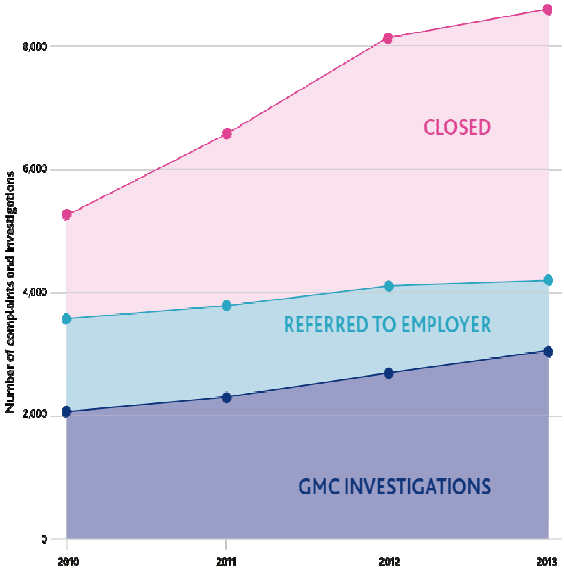
2. THE SIZE OF THE PROBLEM

It is impossible to know how many surgeons are in difficulty or the magnitude of individual problems. There are no acceptable criteria that define 'a surgeon in difficulty'. Assessment of the size of the problem, therefore, necessitates an examination of surrogate measures such as reports to the GMC or NCAS, complaints or surgeon-specific outcome measures.

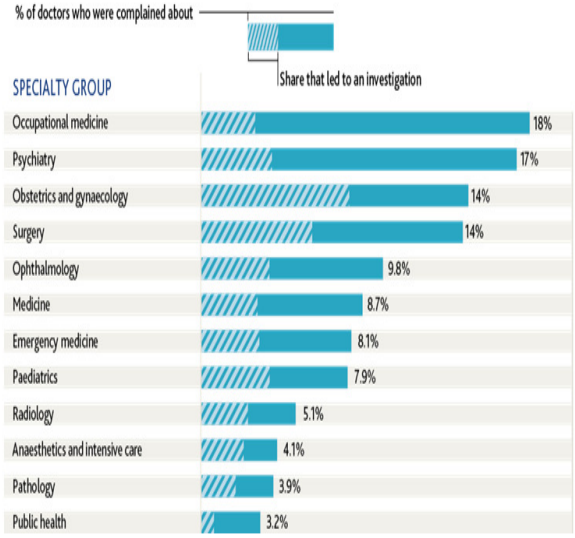
2.1 GMC

The data below are from the GMC:

Total numbers of complaints:



Risk of specialists being complained about:



The frequency of complaints is rising and surgeons are involved on a regular basis. These data, however, do not reveal a specific increase in referrals for surgeons in recent years.

For all doctors age >50yrs, being male and being a specialist increases the risk of GMC referral.

2.2 National Clinical Assessment Service (NCAS)

NCAS data supports the contention that referral rates for doctors are increasing inferring that we are seeing more surgeons in difficulty.

Annual risk of referral to NCAS[7]:

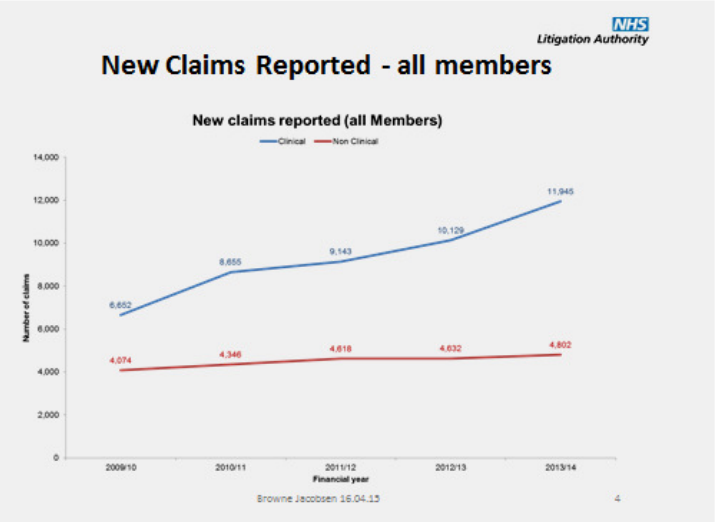
	Rate per 1000 doctor years with 95%CI
Clinical oncology	2.6 (1.5 to 3.7)
General medicine group	2.6 (2.4 to 2.9)
Anaesthetics	3.4 (3.0 to 3.8)
Pathology group	3.6 (2.9 to 4.2)
Radiology group	4.6 (3.7 to 5.4)
Paediatric group	4.8 (4.2 to 5.4)
Surgical group	5.3 (4.9 to 5.7)
Accident and emergency	5.3 (4.6 to 6.0)
General medical practice	5.7 (5.5 to 6.0)
Psychiatry group	9.1 (8.4 to 9.8)
Obstetrics and gynaecology	9.1 (8.2 to 10.0)
All specialties	5.0 (4.9 to 5.2)

NCAS records show just over a hundred doctors and dentists suspended* or excluded from work by the NHS in England at the end of 2013-14. During 2013-14, 155 new exclusions using the *Maintaining High Professional Standards* (MHPS) framework were recorded (see below) and 33 new Performers List (PL) suspensions. This meant a risk of MHPS exclusion of 1.4 doctors/dentists per 1000 in the workforce.

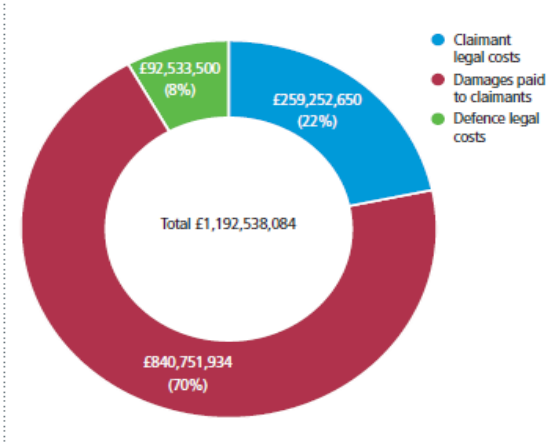
The number of new MHPS exclusion episodes each year is rising for doctors. The number of active exclusions at year-end has risen recently, but active suspensions have fallen steeply, as new episodes have fallen. Some of the increase in use of exclusion can be linked to the increasing workforce at risk. The secondary care medical/dental workforce in England grew by 20% between 2005-06 and 2013-14, from 90,600 to 108,700 (headcounts). These numbers are very small in the context of the total number of practicing doctors.

2.3 National Health Service Litigation Authority (NHSLA)

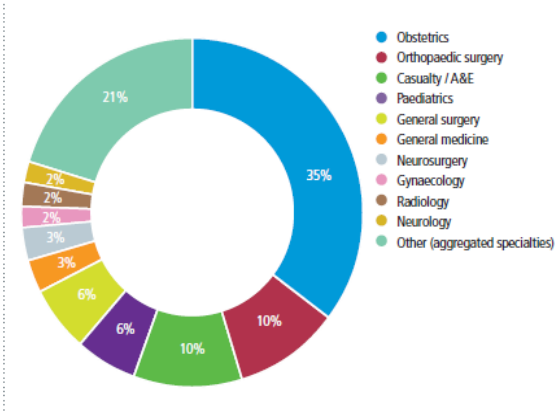
Data from the 2014 NHSLA Annual Report confirm a significant increase in complaints against the NHS[8]:



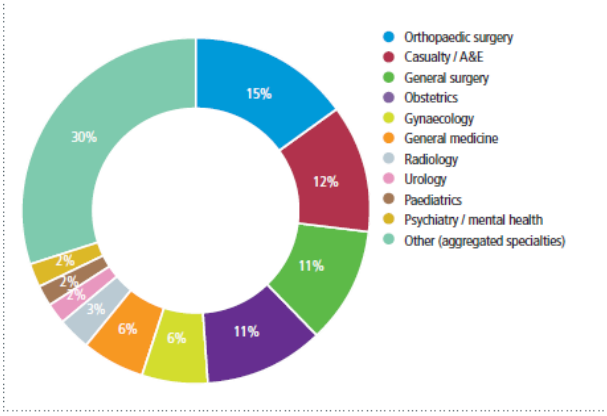
* These data are from Trust and NHS England returns. Suspension usually refers to the GMC administrative action. Employers either exclude or restrict practice under MHPS which is contractually obliged by inclusion in the National Terms and Conditions of Service (unless a Foundation Trust has negotiated a non-standard contract). The GMC can also restrict practice or impose conditions on practice.



Clinical negligence expenditure including interim payments 2013/14



Value of clinical negligence claims received in 2013/14 by specialty



Number of clinical negligence claims received in 2013/14 by specialty

Complaints involving surgeons account for up to 30% of all claims, but less than 10% of all costs. Costs awarded are however a poor reflection of the anguish experienced by surgeons subject to a complaint against their clinical practice.

2.4 Surgeon-specific outcome measures

Consultant Outcomes Publication (COP) is an NHS England initiative, managed by HQIP, to publish quality measures at the level of individual consultant doctor using National Clinical Audit and administrative data. COP began with 10 National Clinical Audits in 2013 and has subsequently been expanded in 2014.

Many institutions and individuals have commented upon the potential benefits as well as drawbacks of this initiative[9,10]. Most support the publication of surgical outcomes in principle but with caveats. This transparency informs patients and provides assurance that care is safe. Importantly it also allows surgeons to benchmark their outcomes against their peers and this leads to improvement in the quality of care for patients. However, many emphasise that individualised data can be misleading and cause unnecessary concern and reputational damage. Further, the statistical finding that a surgeon or

surgical unit's outcomes diverge from those expected should not be an endpoint in itself. It should be the stimulus to the start of a process to explain this divergence. There is a growing consensus that data should be collected on individual surgeons and units, and that this data should only be published after appropriate investigation of any outliers having been completed and action taken.

Much of modern surgical practice relies upon close cooperation between teams of clinicians, nurses and other healthcare professionals. It also relies upon complex infrastructural, managerial and administrative arrangements within provider units. Whilst the availability of high quality performance and outcome data relating to all individual team members is important in order to ensure that a team is functioning well, it is not the most helpful information to make publically available. It is important to recognise that much post-operative morbidity and mortality comes about because of 'failure to rescue', a factor that may not be influenced by the original operating surgeon. Some argue that publication of individual data can also lead to risk-averse behaviour and is not in patients' best interests as it results in surgeons collectively adopting a 'lower risk' practice and patients being denied the opportunity of operations that might benefit them.

There is no evidence to confirm that surgeon specific outcome data is a reliable and robust means of identifying the surgeon in difficulty.

2.4.1 *Experience in UK cardiothoracic surgery*

The Society for Cardiothoracic Surgery in Great Britain and Ireland has reviewed the numbers of colleagues suspended in the last five years. There have been over 30 colleagues who have been suspended or restricted which is greater than 10% of the workforce. As with the data above the reasons for intervention have been varied relating to conduct and capability[11].

2.5 Summary

There is evidence that the numbers of surgeons 'in difficulty' is increasing, although these are relatively small numbers in the context of the total number of surgeons in practice. The incidence of being struck off by the GMC it is 0.003% and similarly about 0.1% of being suspended from practice.

However these incidences have a major negative impact on patients, their local professional community, the organisation they work for and wider public trust.

This does not include the significant trauma inflicted on the individual surgeon, harming their confidence and jeopardising their ability to return to work.

To avoid these deleterious scenarios, the surgical profession needs to identify at an early stage any potential 'surgeons in difficulty' so as to protect patient care and to implement constructive strategies to keep that surgeon delivering safe care.

3. RECOGNISING THE SURGEON IN DIFFICULTY

3.1 Definitions

A concern about a doctor's practice can be said to have arisen where the behaviour of the doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in *Good Medical Practice*.

Concerns include any aspect of a doctor's performance which poses a threat or potential threat to patient safety exposes services to financial or other substantial risk, undermines the reputations or efficiency of services in some significant way, or where activities are outside acceptable practices, guidelines and standards.

Whilst the doctor (or surgeon) in difficulty often has issues with both conduct and capability, it is useful to distinguish these factors:

- Conduct issues include expected standards for specialty/grade, standards set by employer or commissioner and organisational rules and code of conduct.

- Capability issues are defined by 'fitness for purpose' (i.e. is this person able to fulfil the contract they have been employed to operate under?) or 'fitness to practice', which is regulated by GMC and informed by college/faculty.

3.2 Gauging the level of concern

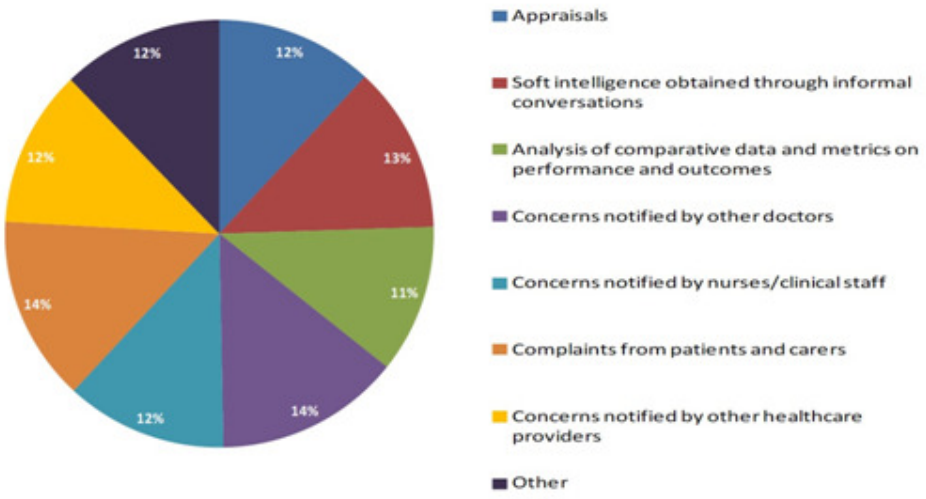
An example of a categorisation framework that allows assessment of level of concern is shown below[12]:

Key	**Low-level indicators**	**Moderate-level indicators**	**High-level indicators**
What reputational risks exist?	Organisational or professional reputation is not at stake but the concern needs to be addressed by discussion with the practitioner.	Organisation or professional reputation may be at stake.	Organisational or professional reputation is at stake.
Does the concern impact on more than one are of *Good Medical Practice (GMP)*?	Concern will be confined to a single domain of *GMP*. May include one of following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action.	Concern affects more than one domain of *GMP*. May include one of the following: clinical incidents, complaints, poor outcome data which requires discussion and perhaps action.	May include a serious untoward incident or complaint requiring a formal investigation. This includes criminal acts and referrals to the GMC.
What factors reduce levels of concern?	De-escalation from moderate to low. Reduction to low or minimal impact. Reduction in the likelihood of recurrence. Evidence of completion of effective remediation.	De-escalation from high to moderate: Reduction in impact to moderate. Reduction in the likelihood of recurrence. Evidence of insight and change in practice.	
What factors increase levels of concern?		Escalation from low to moderate: Increase in impact to moderate. Likelihood of recurrence is certain. No evidence of insight or change in practice.	Escalation from moderate to high: Increase in impact to severe. Increase in likelihood of recurrence. No evidence of remorse, insight or change in practice.
How much intervention is likely to be required?	Insight, remorse and change in practice will be evident. Remediation is likely to be achieved with peer support. The individual doctor has no other involvement in incidents or has outstanding or unaddressed complaints/concerns.	Insight, remorse and change in practice may be evident. Remediation is likely only to be achieved through specialist support. The remediation plan should take no longer than three months to address.	Remediation will only be achieved through specialist support. The remediation plan will take upwards of three months to address and may include a planned period of supervised practice.

Key	Low-level indicators	Moderate-level indicators	High-level indicators
Could the problem have been predicted?	Unintended or unexpected incident		
What degree of interruption to service occurred?	No interruption to the service.		Significant incident which interrupts the routine delivery of accepted practice (as defined in *Good Medical Practice*) to one or more persons working in or receiving care.
How likely is the problem to recur?	Possibility of recurrence but any impact will remain minimal or low. Recurrent is not likely or certain.	Likelihood of recurrence may range from low to certain	Likelihood of recurrence may range from low to certain.
How significant would a recurrence be?		Low-level likelihood or recurrence will have a moderate impact where harm has resulted as a direct consequence and will have affected the natural course of planned treatment or natural course of illness and is likely or certain to have resulted in moderate but not permanent harm. Certain level likelihood of recurrence will have a minimal or low impact.	Low-level likelihood of recurrence will have a high impact (where severe/permanent harm may result as a direct consequence and will affect the natural course of illness such as a permanent lessening of function including non-repairable surgery or brain damage).
How much harm occurred?	No harm to patients or staff and the doctor is not vulnerable or at any personal risk. No requirement for treatment beyond that already planned.	Potential for harm to staff or the doctor is at personal risk. A member of staff has raised concerns about an individual which requires discussion and an action plan.	Patient, staff or the doctor have been harmed.

From NHS Revalidation Support Team, March 2013.

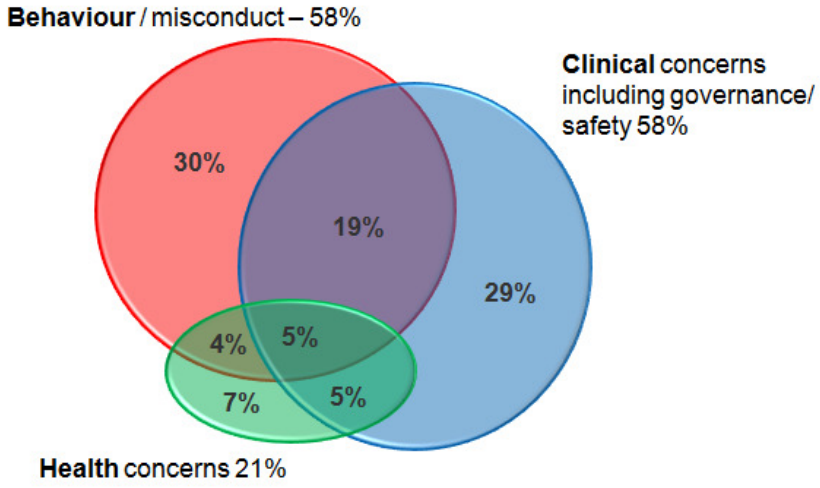
3.3 Source reporting



Concerns originated by source (Designated body survey: Q12)

It is interesting that no single factor predominates here. Outcome results (comparative data) are an uncommon reason for reporting. Appraisals were not a major factor.

3.4 Nature of concerns



It is clear that the majority of concerns do not relate to clinical competence issues alone[13].

4. DEALING WITH THE DOCTOR (SURGEON) IN DIFFICULTY

4.1 MHPS

The standard and accepted HR framework for managing employed doctors in England is set out in a document published by the Department of Health called Maintaining High Professional Standards in the Modern NHS (MHPS)[14]. Analogous, albeit different, procedures exist in the other Home nations.

MHPS describes the procedures which Trusts in England have to follow for handling concerns about conduct, performance and health. MHPS procedures are not mandated for Foundation Trusts, but usually will have been formally incorporated into doctors NHS Terms & Conditions by employers through the Consultant Contract.

MHPS covers Capability (Conduct) and Health, but not all issues.

MHPS has clear defined pathways:

- Part I: Action when a concern arises.
- Part II: Restriction of practice and exclusion.
- Part III: Conduct hearings and disciplinary matters.
- Part IV: Procedures for dealing with issues of capability.
- Part V: Handling concerns about a doctor's health.

Conduct hearings (Part III) are stressful and intimidating. Surgeons should be aware that sometimes they may be inappropriate. Possible reasons for this include the incorrect categorisation of concern, failure to determine if the matter has a professional element, factors relating to conduct outside the employing Trust and a failure to distinguish conduct as opposed to capability issues.

Defence organisations try to get everything seen as a capability issue that should not be handled under conduct procedures (as it is harder to dismiss someone via this route), whereas an employer will often try to pursue conduct rather than capability for the opposite reason. The truth is usually somewhere in between.

Few doctors (surgeons) will find themselves at part IV of the disciplinary process. In these circumstances it is important to consider some key factors: is there a distinction between conduct vs capability? Is the evidence available robust? Have attempts been made at remediation and has NCAS been involved? At this stage the question of capability vs incapacity may arise together with whether the doctor should be referred to the GMC.

4.2 RCS England's Invited Review Mechanism (IRM)

When a Trust or hospital needs an external expert opinion, the Royal College of Surgeons of England can provide an established confidential, bespoke review service – the Invited Review Mechanism (IRM). This mechanism addresses a range of issues such as patient safety concerns at an individual or service level, service delivery, service reconfiguration and requirement for independent expert

opinion on the management of a specific case or series of cases. The aim of the invited review is to support, but not replace, existing procedures.

The College's IRM is a partnership between the RCS Eng, the specialty associations and lay reviewers representing the patient and public interest. The IRM, as a form of peer review, is now regarded as a highly valuable resource to help Trusts and hospitals deal with concerns before they develop into more serious problems.

The IRM is not disciplinary and is totally independent of GMC or NCAS. IRM reports are the property of the employing Trust who remain responsible for managing the situation being reviewed at all times.

Referrals to the IRM are usually from a Chief Executive or a Medical Director.

A criticism of the IRM process is that visits could be perceived as being one-sided. If two surgeons and a lay person arrive at a Trust to investigate a surgeon in difficulty over two days by interviewing nominated colleagues behind closed doors and then undertaking a case review, often of a dozen or more cases, there is little chance for the surgeon to challenge or rebut the evidence against (almost always) him/her or explain the context of the various issues which have been complained about.

The IRM is also currently working with one specialty association to facilitate an early response to emerging concerns by providing independent expert clinical record review service to assist an individual whose performance may be beginning to diverge from nationally accepted norms on nationally reported outcome data.

4.3 National Clinical Assessment Service (NCAS)

NCAS is a national service. It was established in April 2001. NCAS works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to healthcare organisations and to individual practitioners[15]. Its aim is to work with all parties to clarify the concerns, understand what is leading to them and make recommendations to help practitioners return to safe practice.

NCAS does not take on the role of an employer, nor does it function as a regulator. It is solely an advisory body, and the referring organisation retains responsibility for handling the case.

NCAS' mission is to bring expertise to the resolution of concerns about professional practice and, in doing so, improve patient safety.

Anyone can refer to NCAS including self-referral from individual doctors. Findings of NCAS reports and enquiries are not binding on individuals or Trusts.

However, if a Trust wishes to exclude a practitioner, or refer a practitioner for a Trust Capability Panel, MHPS mandates the involvement of NCAS.

Since 1st April 2013 NCAS has been an operating division of the NHS Litigation Authority.

4.4 Specialist Associations (SSAs)

Many of the Specialty Associations participate in national audits. Individuals identified as outliers may be subject to investigation by designated officers of these Associations. The outcome of these investigations and any actions recommended are dependent upon mutual agreement between individuals and SSAs and do not automatically involve third parties such as the GMC, NCAS or the Trust.

Similarly, some SSAs have processes in place to permit outside peer review type investigations of units or individuals. There is no consistency with regards to any mechanism of dealing with the outcome of these deliberations. Furthermore, SSAs may not have indemnity to deal with the doctor in difficulty.

4.5 Deaneries

Clearly the Deaneries are mainly responsible for issues with trainees, although Foundation trainees are employed by Trusts, and therefore are subject to the terms and conditions of their contracts of employment, which will include compliance with Trust policies and procedures. The Forum was concerned that supervision of trainees with one ARCP per year was inadequate. Further, there was general agreement that Deaneries and Schools of Surgery were often too reliant on reports from trainers who were unprepared to be critical. The consequence is that some trainees progress inappropriately.

4.6 Challenges inherent in all processes that review surgical performance

Key challenges for all performance review processes whether they are undertaken by the GMC, NCAS, or a Royal College (i.e. the RCS Eng Invited Review Mechanism) or by a Trust carrying out their own investigation locally, are how it can be ensured that the process being completed is appropriately independent, carried out by suitably qualified experts, and undertaken in an unbiased and impartial manner. A further challenge is how to ensure that any judgments about surgical practice made are evidence-based and drawn from an appropriately wide sample of information.

All such reviews need appropriately robust processes in place to ensure that it can be clearly demonstrated that the views they reach about individual surgical performance are independent, expert, and fair.

Not all surgeons should be trainers and those that are owe it to patient care to be accurate, fair and comprehensive in assessments of trainees.

4.7 Overview

The complexities of managing a surgeon in difficulty mean that it is theoretically possible that the individual under investigation could have their circumstances being considered by an RCS IRM, NCAS, a local Trust investigation and the GMC – the invited review might identify the initial cause for concern, NCAS might work with the employer to manage it, and the GMC might later consider it as part of a ‘fitness to practise’ hearing. This complexity can cause great stress for all those involved and perhaps results in unnecessary duplication of effort.

5. AVOIDING THE PROBLEM

5.1 Revalidation

Revalidation has been successful in that a majority of doctors have collaborated willingly with the appraisal process. The extent to which this has impacted on identifying doctors or surgeons in difficulty has not been demonstrated at this stage. The limited evidence from College help lines or data from the Joint Committee on Revalidation suggests that to date the revalidation process has not at this point been linked with a significant identification of under-performance or a need for advice on managing the revalidation of surgeons in difficulty. Nonetheless, there is general agreement that the revalidation process should be continued and that it will evolve away from being a paper-based process and become a helpful way of ensuring surgeons can demonstrate and maintain high quality practice.

5.2 Team working

Experience from the RCS Eng Invited Reviews emphasises the importance of surgeons participating on a regular basis in team-based activities such as MDT, audit and consultant meetings. Surgeons who regularly discuss problems with colleagues, those who are seen to work collaboratively rather than in isolation, and those who participate in local and national audit are less likely to find themselves becoming 'surgeons in difficulty'.

5.3 Colleague support

The Forum agreed that more emphasis should be placed on mutual colleague support through key stages in their career such as first consultant appointment, managing changes to practice, or preparing for retirement. This applies to all, irrespective of career stage. Many refer to this process as mentoring. Working as teams, and operating as pairs can also be extremely valuable and protective to surgical equanimity.

5.4 Insight

A recurring theme in discussions was that if individuals manifest insight then the probability of encountering problems is greatly reduced. In addition it was recognised that if individuals under investigation have no insight then the probability of resolution is small.

A working definition of insight has been described as 'a tendency to explore intellectually and emotionally how and why I and those I interact with behave, think, and feel as we do and for me to adapt my behaviour accordingly'[5]

An interesting perspective on how behavioural strengths might become weaknesses is illustrated below (Hogan and Hogan 2001)[16].

STRENGTH		DYSFUNCTIONAL BEHAVIOUR
Enthusiastic	Moving away from others	Volatile
Shrewd		Mistrustful
Careful		Cautious
Independent		Detached
Focused		Passive-Aggressive
Confident	Moving against others	Arrogant
Charming		Manipulative
Vivacious		Dramatic
Imaginative		Eccentric
Diligent	Moving towards others	Perfectionist
Dutiful		Dependent

It is very easy to understand why individuals may lack insight into their own activities when seen against an evolution of what were originally considered strengths. This serves to emphasise the importance of surgeons avoiding working in isolation so that any emerging negative behavioural characteristics can be brought to their attention at an early stage and addressed.

5.5 Working environment

Individuals become accustomed and comfortable in familiar environments. This is particularly true of surgeons who evolve patterns of activity around their theatre, day unit or outpatient department. It is important not to underestimate the adverse impact of taking a surgeon out of a familiar environment such as may occur when moving individuals to new Trusts or as a consequence of hospital service reconfiguration. These new areas may seem alien and hostile, and can impact on a surgeon's performance. Nonetheless, there is evidence to suggest that 'good organisation' can be more important than familiarity

Similar problems with regard to 'environment' can occur with the introduction of new technologies. Surgeons may feel keen to adopt these to be seen to be modern and up to date. However, unfamiliarity with new techniques or instruments can lead to problems particularly in the absence of dedicated time for training in the new approach or the opportunity to practice before undertaking the new procedure without support.

Changes in the surgical team can also have an adverse impact on a surgeon's working environment; these can occur through retirement of senior colleagues or with the appointment of new colleagues. The latter emphasizes the critical importance of consultant appointment committees.

5.6 Low morale

The morale of surgeons is low. This is a consequence of many factors which are well known. Repeated exhortations to surgeons to do more with less for seven days a week with no prospect of financial or other reward is unrealistic. Low morale leads to discontent which impacts on standards of practice. Not least comments from political leaders which suggest to the public that patients do not get access to care seven days a week (which is in any case untrue for emergency surgery), because this is inconvenient for doctors, are misguided and demoralizing for surgeons as professionals. Nor are

comments suggesting that surgeons should share the risk with their patients likely to inspire confidence in senior NHS leadership. Public commentary which undermines the confidence and trust which the public must have in their doctors can only be damaging to effective patient care.

5.7 Medical Directors in Trusts

The role of the Medical Director cannot be underestimated. They have a vital role in protecting patients and supporting the service. It would appear that MDs are understandably anxious to protect patient care and the reputation of their organization and are possibly hasty in restricting practice or suspending a surgeon. As explained above, these actions have major implications for the delivery of the service in the short term and in the long term with the negative impact on the confidence of the surgeon and the confidence of the team around them. We would encourage MDs to seek timely independent specialist opinions from the RCS/SSAs if there is a need for restriction/suspension and to ensure all constructive options have been considered. This will involve engagement with MDs ands Trusts to make them aware of the resources available to them.

6. THE GENERAL MEDICAL COUNCIL

The Forum recognises that the GMC is the sole regulator of the medical profession and that this will not change without a change of statute. The Forum welcomed the information that the GMC is anxious to change its 'image' from that of a solely disciplinary organisation to an institution, the prime purpose of which is to protect patients.

The Forum welcomed the fact that the GMC has created a doctor support service and intends to further strengthen this, that it is changing its processes to permit more efficient and more rapid settlement of lower level concerns. The Forum also recognises that the GMC will be less likely to proceed with action if a doctor demonstrates insight or remediation.

Nevertheless, there were many adverse comments expressed about the perceived role of GMC and the way it approaches its fitness to practise activity. These include the excessive time it takes to resolve many cases, a concern that appropriate 'experts' are often not involved in the assessment of cases and a perception that in many occasions individuals, be they managers or clinicians, use the threat of GMC referral as a stick to berate doctors perceived to be acting outwith local interests. This results in inappropriate referrals to the GMC.

Finally, there was agreement that the apparent lack of engagement of the GMC with doctors under investigation was unacceptable. All are aware of the stress of GMC investigation. Recent reports describing a number of suicides by doctors under investigation also provided serious cause for concern.

The Forum was of the opinion that the GMC needs to reassess how it appoints 'experts' and as the only regulator of the medical profession in the UK, needs to consider its role in rehabilitation and pastoral care.

7. MANAGEMENT OF THE SUSPECTED SURGEON IN DIFFICULTY[17]

If you suspect a surgical colleague is in difficulty, then we recommend the following:

- Always act if you have concerns: early identification of issues facilitates successful remediation.
- Avoid stopping a surgeon from operating wherever possible and it is safe to do so.
- Have realistic remediation plans.
- Constructive practitioner/Trust engagement.
- Encourage participation in audit, MDTs, M and M meetings;
- Encourage audit and presentation of verified results.
- Don't place unrealistic conditions on practice.
- Get early third party advice.
- Encourage the surgeon to obtain advice and representation.
- Note, an employer has an obligation to refer cases to NCAS but NCAS is under no obligation to conduct an assessment and there is no obligation on the employer to agree with NCAS recommendations[18].

8. RECOMMENDATIONS

- There should be increased liaison between NHS Trusts (using MHPS), NCAS, GMC, RCS (IRM) and other third parties investigating surgeons in difficulty. Duplicate investigations should be avoided. We would suggest a role for responsible officers in coordinating these investigations.
- Specialist Surgical Associations must play a greater role in assisting Medical Directors and Responsible Officers to analyse and understand the significance of outcome data, and advise when a surgeon's practice is a cause for concern.
- There is an urgent need for more pastoral support for surgeons. On occasions this might prevent them getting into difficulty. Such support might include advice and representation from their professional indemnity organisation and confidential psychological support where necessary.
- There needs to be clear direction for surgeons as to where they should go if they feel they need assistance.
- There is a need to understand the many factors which may result in surgeons finding themselves in difficulty through qualitative retrospective analysis of cases and the effectiveness of the available procedures to address the issues in these cases.
- A more widespread acceptance of the phases of a consultant career would be less likely to lead to burn out. Consultant surgeons should have reduced on-call commitments as they age and support for job plan changes in later life. The skills and experience of the older surgeon can be used constructively to support the team and enhance service delivery
- The Colleges and SSAs need to pay significantly more attention to the importance of training in non-surgical skills, leadership, communication and team working.
- Continued publication of consultant outcome data necessitates adequate resourcing of national audits and a recognition that careful interpretation of data is essential prior to publication including clear processes for investigation of outliers.
- As a profession, surgery needs to consider 'alternative career counselling' for surgeons perceived to be in difficulty. It is important to ascertain how realistic their aspirations of returning to independent consultant practice are. Advocating 'retraining' is rarely a successful option for someone who has already been in independent practice. We are poor at considering alternative career options.
- The Forum was of the opinion that the GMC needs to reassess how it appoints 'experts' and, as the only regulator of the medical profession in the UK, needs to consider its role in rehabilitation and pastoral care.

John MacFie (on behalf of all contributors, listed below)

May 2015

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Appendix 1

Attendees / Contributors

Surgical Forum of Great Britain and Ireland
Thursday 12th March 2015, Royal College of Surgeons of Edinburgh

Mr Kevin Baird	Vice-President, RCPSG
Mr Andrew Beamish	Past President, ASiT
Mr Paul Blair	President, Vascular Society
Mr David Burge	President, BAPS
Mr Michael Davidson	Chairman of Council, BAOMS
Dr Peter Dickson	Senior Adviser (Policy and Stakeholder Engagement) Responsible Officer, National Clinical Assessment Service (NCAS)
Mr John Duncan	Member of RCSEd Council
Dr Frank G Dunn	President, RCPSG
Ms Judy Evans	Member of RCSEd Council
Mr Leslie Hamilton	Representing RCSEng
Professor James Hutchison	Vice-President, RCSEd
Mr David Jones	Representing RCSEng
Mr Simon Kendall	Representing SCTS
Mr Richard Kerr	President, SBNS
Mr Mike Lavelle-Jones	Vice-President, RCSEd
Professor Graham Layer	Members of RCSEd Council
Mr Ian Martin	Medical Director, City Hospitals Sunderland NHS Foundation Trust
Mr Nigel Mercer	President, BAPRAS
Mr John Moorehead	President, ASGBI
Professor John MacFie	Chair, Surgical Forum of Great Britain & Ireland President of the Federation of Surgical Specialty Associations

Attendees

Surgical Forum of Great Britain and Ireland
Thursday 12th March 2015, Royal College of Surgeons of Edinburgh

Mr Michael McKirdy	Vice-President, RCPSG
Professor Antony Narula	President, BAO-HNS
Dr Gerard Panting	CEO, Specialist Professional Indemnity Services Ltd
Mrs Pam Peers	Lay Representative
Mr Michael Reidy	Scottish Representative, BOTA
Mr Ian Ritchie	President, RCSEd
Ms Alison Rooney	Chief Executive, RCSEd
Ms Anna Rowland	Assistant Director Policy, Business Transformation and Safeguarding Fitness to Practise GMC
Mr Mark Speakman	President, BAUS
Professor Sean Tierney	Representing RCSI
Mr Ralph Tomlinson	Head of Invited Reviews, RCSEng
Professor Stephen Westaby	Consultant Cardiac Surgeon, John Radcliffe Hospital, Oxford
Mr Stephen Worrall	Immediate Past Chair, Joint Committee on Revalidation

Surgical Forum of Great Britain and Ireland
Thursday 12 March 2015, 1200 hours

'Dealing with the surgeon in difficulty'

Time		Chair
1200	Welcome to the Royal College of Surgeons, Edinburgh Opening remarks: setting the scene	Mr Ian Ritchie, President, RCSEd Professor John MacFie, Chair, Surgical Forum
Session 1	**Background: recognising the problem**	Mr Simon Kendall, Honorary Secretary, SCTS Mr Nigel Mercer, President, BAPRAS
1215 - 1230	**Do surgeon specific outcome measures help?** - *Professor Stephen Westaby, Consultant Cardiac Surgeon*	
1230 - 1245	**What role for revalidation?** - *Mr Stephen Worrall, Chair, ICC Revalidation Committee*	
1245 -1300	**Is the GMC an effective regulator?** - *Ms Anna Rowland, Assistant Director of Planning*	
1300 - 1315	**Discussion**	
1315 - 1400	*Lunch in the Fellows Library*	
Session 2	**Causes and predisposing factors**	Dr Frank Dunn, President, RCPSG Mr Leslie Hamilton, RCSEng
1400 - 1415	**Lessons from RCSEng Invited Review Mechanism** - *Mr Ralph Tomlinson, IRM lead, RCSEng*	
14.15 - 1430	**Lessons from indemnity schemes** - *Dr Gerard Panting, CEO, Specialist Professional Indemnity Services Limited*	
Session 3	**Looking after the surgeon in difficulty**	Mr Mark Speakman, President, BAUS Professor James Hutchison, VP, RCSEd
1430 - 1445	**NCAS 'conduct or competence'** - *Dr Peter Dickson, Policy & Stakeholder Engagement Adviser*	
1445 - 1500	**A Medical Director's perspective** - *Mr Ian Martin, Medical Director*	
15.00 – 1515	*Discussion / Tea*	
Session 4	**Forum Discussion**	Professor John MacFie, Chair, Surgical Forum Mr Ian Ritchie, President, RCSEd
1515 - 1645	(to which all College and Specialty Association Presidents will be invited to speak)	
1645 - 1715	**Summing up**	