Revalidation Support Team

Supporting doctors to provide safer healthcare

Responding to concerns about a doctor's practice

Case study 1
Secondary care: surgical

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www.revalidationsupport.nhs.uk

Confidentiality and anonymity

This case study has been created to illustrate factors to be considered when addressing concerns about a doctor's practice.

In the interest of protecting the identity of individuals, this report has been compiled from several different cases. All details relating to individuals have been changed.

Source document

Supporting doctors to provide safer healthcare: responding to concerns about a doctor's practice (RST, 2012).

Case study 1
Secondary care: surgical

Organisational culture, clinical governance and patient safety

Mr A, a 59-year-old consultant surgeon, had been in post for 19 years. He performed every type of surgery, including colorectal, breast and vascular operations. There had been informal concerns that both his surgical mortality and complication rates were higher than those of his colleagues, but no data was available. Over the years Mr A had gained a reputation as being given to rudeness and arrogance. This behaviour had never been challenged.

Recently, the newly appointed medical director arrived early in the director of nursing's office to encounter a disturbing conversation between the director of nursing staff and two senior, highly experienced nurses. The nurses were extremely distressed and considering resigning from their posts, but reluctant to explain the reasons. Both of the nurses said that they were afraid to talk because of the bullying culture within the trust. Following discussion and assurances from the medical director that they would be supported and protected, the nurses felt able to talk.

They said that a 45-year-old man had died on the surgical ward one week after major surgery; a death the nurses felt could and should have been avoided. They said that Mr A had been advised to take the patient to theatre for a laparotomy three days previously, by two respected colleagues, but he had refused. The patient's wife had asked the surgeon to transfer her husband to a teaching hospital, just ten miles away, but again Mr A had refused. The patient had been recorded as showing signs of abdominal distension with a low potassium level, but this was ignored.

The nurses believed that this was the second unnecessary death they had witnessed in Mr A's care in the last month. They reported that nursing staff on the ward feared that they would be bullied, if the consultant and his colleagues found out that they had voiced their concerns.

The medical director made a decision to exclude Mr A immediately and to arrange an investigation. He spoke to two other surgeons and attempted to establish why they had not raised concerns previously. They both apologised, but offered no explanation.

Subsequent discussions with other surgeons, trainees and nursing staff revealed six further cases about which there were concerns, all managed by the same surgeon.

Three patients had died and a further two had suffered complications, due to delay in surgical treatment. Mr A had also been responsible for the care of a child with appendicitis. Other surgeons having seen the child had clearly stated their opinion that she should undergo surgery, but Mr A had decided not to operate. Finally, a colleague, who was on call at the time, operated on the child. The child required admission to ITU post-operatively.

During the investigation, an independent surgeon identified serious concerns in every one of the six cases and found that all three deaths had been preventable. The independent expert recommended review of all Mr A's work over the previous two years. The Royal College of Surgeons was then commissioned to review the surgeon's practice. Their rapid response team looked at 500 cases and identified 80 women with breast cancer who had been 'poorly managed', of whom 14 had died prematurely.

The process took 12 months.

Indicative costs

- Exclusion for six months, salary costs, including locum = £200,000
- Royal college review = £10,000
- Legal settlements with patient and families = £1,500,000
- Meetings with patients, relatives, media, over a 12-month period by the medical director and other staff = £200,000
- Cost of training as a doctor at medical school (lost to profession)= £250,000
- Human/hidden costs not quantifiable; 80 women had to be called back for clinical reviews and 14 bereaved families had meetings with hospital managers.

Total cost = £2,000,000 + hidden costs.

Key messages

- Outcome and audit data needs to be of good quality and should be addressed with individuals at the time of the concerns.
- Where an organisational culture tolerates bullying, staff will be inhibited about reporting incidents, leading to increased risk to patients. Organisations should welcome and encourage incident reporting in a "fair blame" environment.

- Colleagues may 'work around' a doctor to avoid confrontation. This may reach extreme levels, as in this case, where a colleague operated on one of Mr A's patients when the colleague was on call. In attempting to achieve the best outcome for the patients, staff were effectively colluding with Mr A, ultimately resulting in patient harm.
- Senior doctors are under obligation to report risks to patient safety in accordance with the GMC's guidance on good medical practice. A doctor's first duty is to patient care and safety, even if this means revealing concerns about a colleague's competence.
- Unprofessional conduct must always be addressed immediately.
- Allowing a general surgeon to undertake all forms of surgery, without any audit or outcome data measurement, represents an unacceptable level of risk.
- Provision of effective appraisal with supporting information, in which a trained appraiser can challenge and offer guidance to formulate a personal development plan, has the potential to address concerns before they escalate, thereby preventing patient harm.