

Fitness to Practise Determination

The following case was heard by a Fitness to Practise Panel. It is presented here to give an example of one possible outcome of breaching a principle in *Good Medical Practice*. It is not intended to give a clear threshold between acceptable and unacceptable behaviour. Each case which comes before a Fitness to Practise Panel is judged on its own merits and assessed on the particular circumstances of the case.

Summary

The doctor, a consultant neurosurgeon, was jointly responsible for the care of a patient admitted to hospital. The doctor went on leave shortly afterwards and did not formulate a management plan for the patient during his absence, nor make adequate arrangements for cover. The patient subsequently died.

Relevant paragraphs of *Good Medical Practice*

The case relates to the *Good clinical care* section of GMP, specifically paragraphs 3a and 3f on providing good clinical care. It also relates to *Working with colleagues*, in particular paragraph 41b on working in teams, paragraph 48 on arranging cover, and paragraph 50 on sharing information with colleagues.

Determination on impaired fitness to practise

At the start of these proceedings, in [date removed], admissions were made on Dr X's behalf in respect of some of the facts alleged. Subsequently, the Panel made findings in respect of those allegations which were not admitted. Having heard all the evidence relevant to its fact-finding stage, the Panel then announced that, with regard to allegations 9a, 9b (i) (ii) and (iii), 9c, 9d, 9e, 9f (ii) and 9g, Dr X's conduct was inadequate, not in the best interests of Patient A and fell significantly short of the standards to be expected of a responsible medical practitioner. The hearing then adjourned, there being insufficient time in which to conclude.

Today, the Panel's task has been to consider, on the basis of the facts which have been found proved, whether or not Dr X's fitness to practise is impaired by reason of misconduct.

At the relevant time, Dr X was working as a Professor of Neurosurgery, Consultant Neurosurgeon, at the XXXX Hospital, XXXX.

On [date removed], Patient A was admitted to the XXXX Hospital, at 12:02 via Accident and Emergency, for investigation of a frontal mass brain lesion. Patient A's history, according to the evidence of his widow, included headache, back pain, vomiting, loss of co-ordination and an aversion to light. At 21:30, Patient A was admitted to the XXXX Hospital ("the Hospital"), under the care of Dr S, for continued investigation and management of the lesion. Dr S asked Dr X to review Patient A.

At Dr S's request, Dr X reviewed Patient A on [date removed]. He recorded in Patient A's medical notes that, although an abscess was unlikely, an infectious cause could not be ruled out absolutely; that a further MRI scan would be helpful; and that surgery was likely to be needed. However, Patient A's infection first needed to be dealt with. Dr X also recorded that he would see Patient A again after the further MRI scan. He formed the opinion, which he communicated orally to Dr S, that Patient A was suffering, not from an abscess but from a glioma, which would need resection and that there was an infection present, the source of which was as yet unidentified. That infection would need to be treated before such surgery could take place.

From [date removed] onwards, Dr X undertook responsibility for the principal management and treatment of Patient A's neurosurgical care and needs. However, Dr S undertook to investigate what was perceived at the time to be an inter-current infection. Overall, responsibility for the patient's care remained a joint one.

On [date removed], Patient A underwent a Magnetic Resonance Imaging (MRI) scan. Dr W, Consultant Neuro-Radiologist reported on the scan, stating that:

"These [findings] are appearances of intrinsic tumour, and high grade glioma seems likely. The ragged walls of this lesion make pyogenic abscess unlikely, but tuberculous abscess is a remote possibility".

On [date removed], in the presence of Dr S, Dr X further reviewed Patient A and recorded in Patient A's notes:

"Dear xxxx,
The MRI scan shows as you know the lesion identified with the CT.
Unfortunately it looks intrinsic but once he is over his current infection a partial removal would be possible. I will see him in clinic with repeat scan on [date removed]."

On or about [date removed], Dr X made arrangements for Patient A to be reviewed in his outpatient clinic after a further scan, on or about 3 April XXXX. Dr X was due to go on leave on or about 23 March XXXX. At no time did he inform Dr S in terms that Patient A should remain an in-patient until his (Dr X's) return from leave and a further review take place on or about 3 April XXXX; nor did he make a note in Patient A's records of any plan or intention that Patient A remain an in-patient until such further review by him could take place.

Dr X did not properly maintain on his differential diagnosis of Patient A's condition the realistic possibility that the lesion might, in fact, be an abscess rather than a tumour; he did not formulate a management plan to the effect that Patient A needed to remain an in-patient on continued intravenous antibiotics and subject to close

neurological observations. Dr X did not record in Patient A's notes any in-patient management plan at all, nor did he inform Dr S that Patient A should remain an inpatient on intravenous antibiotics. In addition, Dr X did not establish appropriate consultant neurosurgical cover for the period of his absence and did not tell Dr S whom to approach in order to obtain a consultant neurosurgical opinion during Dr X's absence on leave.

Dr X did not make an appropriate written record, informing those charged with the immediate care of Patient A, that he was to be absent from the hospital on leave; nor did he record in writing any arrangements that he had made for cover during his absence.

In considering whether or not Dr X's fitness to practise is impaired, the Panel has had regard to all the evidence adduced. It has been assisted by the transcripts of the proceedings held in [*date removed*], by the submissions made by Mr H on behalf of the General Medical Council and by those made by you on Dr X's behalf. However, the Panel is aware that the question of whether or not Dr X's fitness to practise is impaired is a matter for the Panel, exercising its own independent professional judgment.

Mr H has submitted that Dr X's failures in respect of Patient A fall into three broad categories, namely, 'Management', 'Communication' and 'Cover'.

As to 'Management', he said that the possibility, even if remote, of abscess should have been maintained on Dr X's differential diagnosis and that a management plan that provided for Patient A to remain an in-patient on intravenous antibiotics was required. He cited the evidence of Dr W who stated that "it was a cavitating lesion which could have been an abscess or a tumour...the general rule is to treat them all as abscesses until proved otherwise", and that "...abscess could not be excluded." Dr W said of such lesions "...most of these are tumours" but, significantly, added that: "a sufficient proportion and a worrying proportion are abscesses." Dr W conceded that he could not remember whether he had specifically told Dr X that an abscess could not be ruled out. However, he said that if he had not spelled it out, that would have been "because it was basic neurosurgery", which was so obvious that he did not need to say it. Dr D, the expert witness called on behalf of the GMC, said that a management plan "should have been agreed...and written down...particularly as Dr X was going on leave" and that Patient A should have stayed "perhaps for a longer period of time than he had been in the hospital for further surveillance."

On the issues of 'Communication' and 'Cover', Mr H referred the Panel to the evidence of Dr S (which it had accepted in making its finding on the facts). Dr S told the Panel that Dr X did not say that he wished Patient A to remain an in-patient on intravenous antibiotics nor did Dr X identify another neurosurgical consultant from whom Dr S should seek an opinion if that became necessary. Mr H also referred the Panel to the evidence of Mr M, Consultant Neurosurgeon. Although Mr M agreed that he had, on occasions, provided cover for Dr X, he could not remember being asked to do so for Patient A. Despite his imperfect recall of the events of [*date removed*], his evidence was that, if he had been asked to provide cover, then he would have expected to remember the case, given the tragic outcome. Mr M stated: "given the unhappy events which followed this patient, I find it hard to believe that I

could have been discussing the management of a patient who was soon to come to this unhappy end without being reminded of it at the time.” Pressed further as to whether he could recall whether Dr X had asked him to attend or to be available to attend a patient who was sufficiently likely to have a brain abscess, such that neurosurgical input might be required, he responded: “No, I cannot recall his asking me to do that.”

On behalf of Dr X, you have invited the Panel to consider his acts and omissions in the context of his otherwise unblemished career, both before the events that brought him before this hearing and subsequently. You have submitted that he did not have sole clinical responsibility for the management of Patient A and that the practitioner with the real skill in treating infection, whether coincidental to the lesion or not, was the physician, Dr S. You have noted that Dr X was not alone in believing the lesion to be a glioma. You submitted that Dr S was experienced and able to exercise his own clinical judgment in discharging Patient A. You asked the Panel to accept that Dr S could have obtained the opinion of a consultant neurosurgeon had he felt that was required.

The Panel has taken account of the GMC’s ‘Indicative Sanctions Guidance’. That document states [at S1-2 paragraph 1] that:

“...it is clear that the GMC’s role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practise either with restrictions on registration or at all.”

The principle that the GMC should be able to take action in relation to a doctor’s registration “in the interests of the public” is well established, as is the fact that the public interest includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Panel has also considered the GMC’s guidance ‘Good Medical Practice’ (July 1998 edition) which sets out the duties and responsibilities of doctors. ‘Good Medical Practice’ places a duty upon doctors to: “Make the care of your patient your first concern”, and “Work with colleagues in the ways that best serve patients’ interests”. Under the heading ‘Good Clinical Care’, the guidance makes clear that in providing care, doctors must: “be competent when making diagnoses...”, “keep clear accurate legible and contemporaneous patient records which report the relevant clinical findings, the decisions made...and any drugs or other treatment prescribed”, and “keep colleagues well informed when sharing the care of patients”. Under the heading ‘Working with Colleagues’ the guidance states that: “Healthcare is increasingly provided by multi-disciplinary teams”, and that “...you are expect to work constructively within teams.”

The Panel has taken account of the all the authorities to which it has been referred. It noted in particular the case of *Roylance v General Medical Council* [2001] 1 AC 311 as to the issue of serious professional misconduct, along with the case of *Bijl* [Privy Council Appeal No 78 of 2000] as it relates to the disciplinary process and an “otherwise competent and useful doctor who presents no danger to the public”. Finally the Panel has taken particular note of the case of *GMC v Sir Roy Meadow*

with the Attorney General intervening [2006] EWCA Civ 1390 in which LJ Auld ruled that 'misconduct' as a category of impairment of fitness to practise was not a lower threshold for disciplinary intervention by the GMC than the old concept of 'serious professional misconduct'.

On the basis of the facts proved, the failures by Dr X represent clear departures from the principles of 'Good Medical Practice' and the standards of conduct, competence and care with which all doctors must comply. Although the Panel accepts that the failures by Dr X which it is asked to consider are limited to just one patient and are not said to be representative of the overall standard of his practice as a consultant, nevertheless those failures represent serious departures from a significant number of the requirements of 'Good Medical Practice'. Dr X failed to maintain abscess on his differential diagnosis. In any event he should have devised a management plan which he should have recorded and communicated to the other health care professionals charged with the care and treatment of Patient A. That plan should have provided for, at the least, continued intravenous antibiotic treatment as an in-patient. Dr S and others would then have been clear about Dr X's intentions for the management of Patient A. The plan should also have indicated who would be responsible for providing neurosurgical cover during Dr X's absence. It noted that the case in question did not involve a patient in an NHS hospital where the duty consultant would assume responsibility if required. The Panel also noted the evidence of Mr D that the condition of patients with brain lesions can change rapidly (Day 2 page 72).

The Panel rejected the proposition that Dr X can divest himself of his responsibility for ensuring appropriate cover by suggesting that another practitioner, namely Dr S, could have sought a specialist opinion among the other local consultants if he felt that was necessary.

Dr X's actions and omissions, taken as a whole, fell significantly below the standards reasonably to be expected of a competent experienced consultant. In all the circumstances and having applied the relevant tests, the Panel has concluded that his fitness to practise is impaired by reason of his misconduct.