Heart of England NHS Foundation Trust

Strictly Private and Confidential

Report on Investigation into Concerns Regarding the Personal Conduct and Clinical Competence of Mr Ian Paterson, Consultant Breast Surgeon

Contents

Executive Summary

In June and July 2007 letters raising concerns about the personal conduct and clinical competence of Mr Paterson, Consultant Breast Surgeon were received initially from Mr Hemant Ingle, Consultant Breast Surgeon, and subsequently also from Dr Indy Fernando and later from Dr Andy Stockdale, Consultant Oncologists.

It was agreed that these concerns required formal investigation and that this should be carried out in accordance with the Trust's Disciplinary Procedure for Medical Staff.

The Investigation was undertaken by Dr Rex J Polson (Case Investigator) and Mr Ian Cunliffe, Medical Director as Case Manager.

The areas of concern informed the terms of reference for the investigation and were as follows:

1 Patients are being recommended inappropriately for mastectomy. There is one specific concern that in his private practice, Mr Paterson recommended a male patient for a mastectomy inappropriately.

2 Incomplete mastectomies are being undertaken.

3 Patients are being recommended for breast reconstruction surgery when this is not clinically appropriate.

In addition the Trust also investigated matters in relation to Mr Paterson's personal conduct towards colleagues. It was alleged that Mr Paterson inappropriately made contact with a fellow surgeon's ex-colleagues seeking information as to whether there had been any concerns about his performance as a trainee doctor. Secondly it was alleged that Mr Paterson promulgated inaccurate information concerning the same fellow surgeon's competence to colleagues in person and at MDT meetings resulting in the surgeon feeling professionally undermined.

To investigate these allegations a series of interviews were arranged with individual witnesses (Appendix 2) and these were held from 28 September to 13 December 2007.

As part of this investigation, it was necessary to obtain the views of an external Breast Surgeon on the clinical issues that had been raised. This review was undertaken by Mr Colm Hennessy from 12 to 29 November 2007.

Overall, from the findings of the investigation, including the clinical review, it is clear that there are justifiable concerns with regard to Mr Paterson's clinical practice surrounding his mastectomy technique and also his personal conduct in regard to Mr Ingle and the breast MDT.

In summary for the three clinical complaints: I conclude that the first complaint about the clinical care of male patient seen privately was not substantiated; whilst the next two complaints appear to have been substantiated. In addition, I believe the complaints into the personal conduct issues were also substantiated.

The recommendations from the investigation are as follows:

1. A thorough review of the MDT needs to take place involving all members of the team, reviewing data and functioning within the unit.
   This recommendation is already in progress.

2. The practice of shaves at mastectomy should cease. The MDT needs to be confident that a mastectomy means as close to 100% as possible of the breast tissue is removed. Mr Paterson should "cease sub-total mastectomy, cleavage-sparing mastectomy and shavings with mastectomy, unless previously agreed with the MDT or if clinically necessary during surgery." Mr Paterson has already agreed this, and he has also agreed to demonstrate his "technical ability to carry out a total mastectomy to a satisfactory standard by allowing an independent, Consultant Surgeon to observe him carrying out these procedures on a minimum of five patients".

3. The dysfunctional relationships within the MDT need to be repaired. A successful outcome is only likely to be achieved through significant compromises. It is possible that some improvement can be achieved through facilitated meetings.
   Processes to address this have already begun and Mr Paterson has agreed "to work constructively with the MDT, ensuring all cases go through the MDT and are fully discussed and consensus opinion followed."

4. The leadership within the MDT needs to have the support and strength to deal with the difficult situations encountered.
   This has been addressed with a new independent chair for the MDT having been put in place to try to ensure a consensus view prevails.

5. Reconstruction decisions should be taken to the MDT.
   As mentioned above Mr Paterson has agreed to ensure all cases go through the MDT and consensus opinion is followed.

6. The WMCIU data should be reviewed with regard to margins of excision and shaves. It may require going through the histology reports. Data relating to those with recurrences and those identified as having a second or subsequent operation after mastectomies should be reviewed.

   The Breast MDT should be asked to review the management of all patients with breast cancer who have disease recurrence after what was believed to be curative treatment. The size and location of cancers and whether or not there was multifocality should be considered.

Indeed every cancer MDT within the Trust should be encouraged to do this, if they are not doing so already.

This should start as soon as reasonably practicable.

7. The notes for all patients of Mr Paterson's who have had sub-total mastectomy, cleavage-sparing mastectomy and shaves with mastectomy, should be reviewed, audited and if necessary given further treatment.

8. A detailed review should take place of immediate reconstructions over the past 3 years.

9. A database for all patients undergoing breast cancer surgery should be set up or adapted to allow ongoing, continuous audit of patient outcomes. All of those treating patients should be encouraged to include patients seen privately on the same database.

10. Treatment policies relating to breast cancer, including mastectomy, excision margins, reconstruction and neo-adjuvant therapies should be formally agreed by the MDT. These policies should be presented in an annual audit.

11. Ensure that appropriate guidelines are agreed to allow the MDT to make decisions about which patients are suitable for primary and secondary breast reconstruction; and ensure the appropriate distribution of this workload.

12. Work is needed to improve the relationships both within the Breast MDT and in the team generally. Everyone involved accepts that things need to change which improves the likelihood of a successful outcome.

13. A facilitated mediation session between Mr Paterson and Mr Ingle should be helpful to them both and to the wider Breast Unit.

14. Mr Paterson was wrong in making enquires about Mr Ingle in the way he did and he accepts this. The Trust needs to make it clear to Mr Paterson that such behaviour is not acceptable and will not be tolerated.

1. Introduction

Mr Ian Paterson has been employed as a Consultant Surgeon working in the Breast Services Unit since 1 March 1998.

In June and July 2007 letters raising concerns about the personal conduct and clinical competence of Mr Paterson were received initially from Mr Hemant Ingle, Consultant Breast Surgeon, and subsequently also from Dr Indy Fernando and later from Dr Andy Stockdale, Consultant Oncologists.

It was agreed that these concerns required formal investigation and that this should be carried out in accordance with the Trust's Disciplinary Procedure for Medical Staff

I, Dr Rex J Polson BSc, LLM, MD, FRCP; Consultant Physician with a specialist interest in Gastroenterology, was appointed as the Case Investigator with Human Resources support provided by Mrs Alison Money, HR Business Consultant.

2. Terms of Reference

A letter was sent to Mr Paterson from Mr Cunliffe (Case Manager) dated 24 July 2007 which advised him of the allegations that had been made against him and explained that his attendance would be required at an investigatory meeting at which he would have the right to be accompanied.

The three areas of particular concern were:

1 Mr Paterson's personal conduct and clinical judgment in relation to a private patient. It was alleged Mr Paterson recommended a mastectomy when this was not clinically necessary. Furthermore, Mr Paterson's conduct in explaining the associated costs of the procedure to the patient lacked probity and fell below the standards expected of consultants as detailed in 'A Code of Conduct for Private Practice'.

2 Mr Paterson's personal conduct in relation to a colleague - on appointment of a new colleague, Mr Hemant Ingle, Mr Paterson:

   a. Inappropriately made contact with Mr Ingle's ex-colleagues seeking information as to whether there had been any concerns about his performance as a doctor. This was undertaken without the Trust's permission and was outside any Trust policy and procedure.

   b. Promulgated inaccurate information concerning Mr Ingle's competence to colleagues in person and at MDT meetings resulting in Mr Ingle feeling professionally undermined.

3 Mr Paterson's clinical practice in undertaking mastectomies and breast reconstruction gives cause for concern. The specific concerns are that Mr Paterson:

a. Undertake incomplete mastectomies

b. Advise patients to undergo breast reconstruction surgery when this is not clinically appropriate.

For clarity, these allegations were presented slightly differently in a letter dated 6 September 2007 from Mr Paterson to Dr. Connell, Mr Paterson's representative at the Medical Defence Union (MDU) as follows:

1 Patients are being recommended inappropriately for mastectomy. There is one specific concern that in his private practice, Mr Paterson recommended a male patient for a mastectomy inappropriately.

2 Incomplete mastectomies are being undertaken.

3 Patients are being recommended for breast reconstruction surgery when this is not clinically appropriate.

In addition the Trust is also investigating matters in relation to Mr Paterson's personal conduct towards colleagues. It is alleged that Mr Paterson inappropriately made contact with a fellow surgeon's ex-colleagues seeking information as to whether there had been any concerns about his performance as a trainee doctor. Secondly it is alleged that Mr Paterson promulgated inaccurate information concerning the same fellow surgeon's competence to colleagues in person and at MDT meetings resulting in the surgeon feeling professionally undermined."

3. Methodology

3.1 Interviews

To investigate these allegations further a series of interviews were arranged with the following individuals and these were held on the dates shown:

Mr Misra Budhoo (MB)	CD Breast Surgery	28 September 2007
Dr Indy Fernando (IF)	Oncologist	2 October 2007
Mr Alan Jewkes (AJ)	Lead Breast Surgeon	5 October 2007
Mr Bala Subramanian (BS)	Breast Surgeon	9 October 2007
Dr Andrew Stockdale (AS)	Oncologist	12 October 2007
Mr Hemant Ingle (HI)/BMA	Breast Surgeon	19 October 2007
Dr Chris Fletcher (CF)	Radiologist	30 October 2007
Mr Ian Paterson (IP)/ MDU	Breast Surgeon	9 November 2007
Mr Colm Hennessy (CH)	External Reviewer	12 November 2007
Mr Hennessy / IC / CA	External Reviewer	29 November 2007
Miss CC Kat (CK)	Plastic Surgeon	6 December 2007
Dr Matthew Wallis (MaW)	Radiologist (phone)	11 December 2007

Mr Mark Wake (MW)	Cancer Lead	13 December 2007
Sr Clare Bate (CB)	Breast Care Nurse	13 December 2007
Dr Bruce Tanchel (BT)	Pathologist	13 December 2007

Each meeting followed a similar format with questions around when the individual started working for the Trust, their own involvement in the Breast Services Unit including in particular relationships within the MDT meetings and where relevant their comments on clinical care for patients. Detailed notes from each of the interviews are included as Appendix 1.

It is important to note that despite repeatedly chasing the notes from the meetings with Mr Paterson, Miss Kat and Dr Fletcher, these have not been returned. Therefore a final communications was sent to these individuals informing them that their draft statements would be used if agreed statements were not received by the specified deadlines. All other individuals have confirmed that the notes are a true and accurate reflection of the discussions that took place.

3. 2 Clinical Review - **Obtaining an External Breast Surgeon Review**

As part of this investigation, it was necessary to obtain the views of an external Breast Surgeon on the clinical issues that had been raised. Therefore, in August 2007, the Trust approached Mr Hugh Bishop who confirmed he would be willing to undertake the External Breast Surgeon review.

However, Mr Paterson objected to this appointment and therefore the Trust obtained a further list of Breast Surgeons who could possibly carry out the review. After checking this with Mr. Paterson, it was mutually agreed that Mr Colm Hennessy, Consultant General Surgeon with a special interest in breast surgery at North Tees and Hartlepool NHS Trust, would undertake the review.

Mr Colm Hennessy came to the Trust on 12th, 13th and 29th November 2007 and held meetings with several clinical colleagues as detailed below:-

Mr Ian Cunliffe (Medical Director Surgery and Case Manager), Dr Rex J Polson (Consultant Gastroenterologist and Case Investigator), Mr Misra Budhoo (Clinical Director Surgery), Drs Andrew Stockdale and Indy Fernando (Consultant Clinical Oncologists), Dr Chris Fletcher (Consultant Radiologist), Drs Peter Colloby and Bruce Tanchel (Consultant Pathologists), Mr Bala Subramanian (Consultant Surgeon), Mr Hemant Ingle (Consultant Surgeon), Mrs Claire Bate (Breast Care Nurse), Mr Alan Jewkes (Consultant Surgeon), Miss CC Kat (Consultant Plastic and Reconstructive Surgeon) and Mr Ian Paterson (Consultant Surgeon). A discussion with Mr Mark Wake, Lead Cancer Clinician took place by phone.

Mr. Hennessy also undertook case note reviews on the 12th, 13th and 29th of November 2007. Details regarding the surgery and histology were recorded. He reviewed the notes of 61 cases identified by Drs Fernando and Stockdale, consultant oncologists, and Mr Ingle, consultant breast surgeon in whom they believed there were significant concerns with regard to the surgical treatment that had been undertaken by Mr Paterson.

I am extremely grateful to Mr Colm Hennessy for his detailed and well presented interim report of 8 December 2007 (received 14 December 2007) and for his final report of 21 January 2008 (received 6 February 2008) and for the clarity of his conclusions and the recommendations (Appendices 4 and 5, respectively).

4. Findings

Complaint

Patients are being recommended inappropriately for mastectomy. There is one specific concern that in his private practice, Mr Paterson recommended a male patient for a mastectomy inappropriately

Evidence

There are clearly differences in opinion between Mr Paterson and Mr Ingle around the details of this case. Mr Paterson claimed and indeed produced a supporting letter from his private secretary to the effect that the price quoted for the procedure was an administrative error, he claims it should have been for a breast biopsy (B2800) but instead was for ultrasound and biopsy (B2880); Mr Paterson says he was not considering a mastectomy (Ref: Appendix 3).

In contrast Mr Ingle reports that "according to the GP letter, this patient required urgent surgery on his breast. The tone of the letter indicated that he most likely had breast cancer." After examining the patient, Mr Ingle "couldn't understand why the patient required urgent surgery." He performed a biopsy on the patient which did not show cancer and so surgery was not required.

Mr Hennessy's comments on this case are:

"From the case notes it would appear that Mr Ingle was entirely correct to carry out a core biopsy for gynaecomastia rather than a mastectomy. The correspondence relating to this matter indicates that the patient was quoted a price for a mastectomy rather than proceeding to a core biopsy. Mr Ingle is clear about what the patient has described. Mr Paterson suggests that the issue of the quote for the procedure was an administrative error."

When I initially reviewed this patient's NHS hospital notes there was a fax copy of the GP referral to the Trust on the Pan-Birmingham Cancer Network "Urgent Referral for Suspected Breast Cancer" form filed in the notes. The clinical details from the GP were given as "Seen Mr Paterson – Parkway – Excision biopsy recommended." (Ref: Appendix 3) This would support the view put forward by Mr Ingle and Mr Hennessy's comments above.

More recently when this patient's NHS notes were seen they also included a copy of the letter from Mr Paterson to the patient's GP (Ref: Appendix 3). I believe this letter will not have been seen by Mr Hennessy or Mr Ingle. In this letter Mr Paterson states "I suspect this is gynaecomastia ... and I would be keen to needle this for cytology but X is keen to have it removed for both diagnostic and symptomatic relief purposes and I think he is right. I will write to you again on the day of his surgery in the next week or so." This confirms that Mr Paterson's was not planning a mastectomy, and an excision biopsy would be in keeping with the procedure code in the letter from his secretary.

Presumably this letter was also not available for Mr Ingle when he saw this patient and his interpretation of the GP referral and presumably the patients' comments would support his view. This letter however supports Mr Paterson's comments and it is unfortunate that it wasn't available earlier.

During the interview process, individuals were also asked if they had any concerns with regard to probity around Mr Paterson's private practice. Many of those I spoke to acknowledged that as Mr Paterson works extremely hard in his NHS practice he does likewise privately.

Mr Paterson confirmed that the management of his private patients are discussed at a MDT meeting held at Little Aston Hospital with Dr Tal Lateif providing consultant oncology input. Mr Paterson suggested that as he works with another oncologist privately this may upset the Trust oncologists, but Drs Fernando and Stockdale said this was not the case. All witnesses agreed that it was appropriate that private patients are discussed at an MDT and indeed most surgeons would discuss their private patients with cancer at the Trust MDT, although the numbers of such patients are generally far fewer than for Mr Paterson. There was some concern about the robustness of any discussion within this private MDT and that it is not part of any formal peer review process (AJ).

Individuals were also asked if they were aware of any inappropriate transfer of work between the NHS and private sector in either direction. Overall there were no consistent or specific concerns. It was mentioned that there had been reports of Mr Paterson specifically trying to see patients from certain postcode areas in the NHS clinic at Solihull with several of these subsequently being managed privately. No-one reported that they felt that this was still happening or that it was necessarily wrong. Occasional patients transfer from private to NHS care, as they do from other clinicians, but their subsequent care is aligned to that of all NHS patients as it should.

Findings

From the evidence available initially it was not certain whether a mastectomy was actually recommended for this male patient first seen privately by Mr Paterson. However, from the urgency of the GP referral on a Breast cancer referral form and from Mr Ingle's interviews with Mr Hennessy and me I had originally concluded that after his consultation with Mr Paterson this patient had been led to believe that the risk of him having breast cancer was higher than was probably likely.

Mr Paterson's letter to the GP confirms that he was not planning a mastectomy although it remains unclear what the patient may have been thinking as removal of the breast lump had been planned for in the next week or so.

In view of this letter which has only recently become available I conclude that this complaint was not substantiated

Complaint

Incomplete mastectomies are being undertaken

Evidence

All of those I spoke to were concerned about cases in which there is unexpected disease recurrence and agreed that this was more likely to occur in cases where there was more residual breast tissue or where tumour extended nearer to resection margins. Mr Paterson argued that he was also keen to remove all breast tissue but he claimed it was "perfectly possible to remove the cancer, leaving fat not breast tissue". By doing this he feels he can achieve an improved cosmetic result. (Ref: Appendix 5)

Mr Paterson also argued that his practice of taking shaves at surgery helped reduce his recurrence rate. He also claimed that by operating with Miss Kat he had a check to ensure that all breast tissue had been removed; but as mentioned in Mr Hennessy's report Miss Kat says that she does not go looking for residual breast tissue.

The oncologists (IF and AS) and Mr Ingle provided details of patients they believed had had incomplete mastectomies by Mr Paterson and these cases were reviewed by Mr Hennessy who concluded:

> "There are justifiable concerns relating to excision margins and risk of recurrence. The practice of mastectomy shaves seems to add to the concerns

regarding this issue. It is clear that Mr Paterson wishes to provide the best possible cosmetic outcome from a mastectomy and clearly a tidy scar and some cleavage are popular with patients. It is obviously impossible to prove whether or not all residual chest wall tissue after mastectomy contains breast glandular tissue. My surgical interpretation of the imaging reports and hard copy supports the concern raised by oncology and surgical colleagues. Not all of the features on the images can be put down to post-operative scarring, as suggested by Mr Paterson."

Mr Hennessy went on to recommend that "the practice of shaves at mastectomy should cease. The MDT needs to be confident that a mastectomy means as close to 100% as possible of the breast tissue is removed. If all of the breast tissue is removed a flat chest should be achieved, therefore cleavage sparing mastectomy will not be carried out."

Mr Paterson did comment that he had written a paper relating to shaves taken at mastectomy which was due to be published in 2008 in "The Breast Journal". This paper titled "Effect of Cavity Shaving on Re-Operation Rate after Breast Conserving Surgery" has been reviewed by Mr Hennessy. As for other publications on this subject the practice of cavity shaves is described in breast conserving surgery rather than mastectomy and so is of limited relevance to the current investigation. Indeed Mr Hennessy points out that the paper states informed consent "was obtained for all patients", but the "mastectomy patients, who are subject of the present investigation, were not consented for cavity shaves".

Mr Hennessy reports that this paper describes "the role of the MDT in regard to the decision to re-operate if margins were not clear"; and then continues the current investigation suggests "the MDT has had difficulties relating to excision margins after mastectomy".

The timing of the changes in practice described in this paper was from March 2003 which would seem to be linked to the concerns raised by the oncologists and presented in December 2002.

Findings

From the evidence in Mr Hennessy's clinical review I conclude that this complaint was substantiated

Complaint

Patients are being recommended for breast reconstruction surgery when this is not clinically appropriate

Evidence

Dr Fernando, Dr Stockdale and Mr Ingle provided details for patients in whom they felt breast reconstruction surgery had been carried out by Mr Paterson when it was not clinically appropriate and these were reviewed by Mr Hennessy who stated:

> "Clearly the policy regarding reconstruction should have the full support from the MDT. It is obvious that in some of these cases there was conflict within the MDT."
> "The oncology opinion regarding reconstruction and the place of radiotherapy and chemotherapy is valuable. It is clear that some of the oncological views in these cases were not fully taken into account."

He went on to recommend that "reconstruction decisions should be taken to the MDT."

Findings

Again from the clinical review I conclude that this complaint was substantiated.

Complaint

Personal conduct issues:

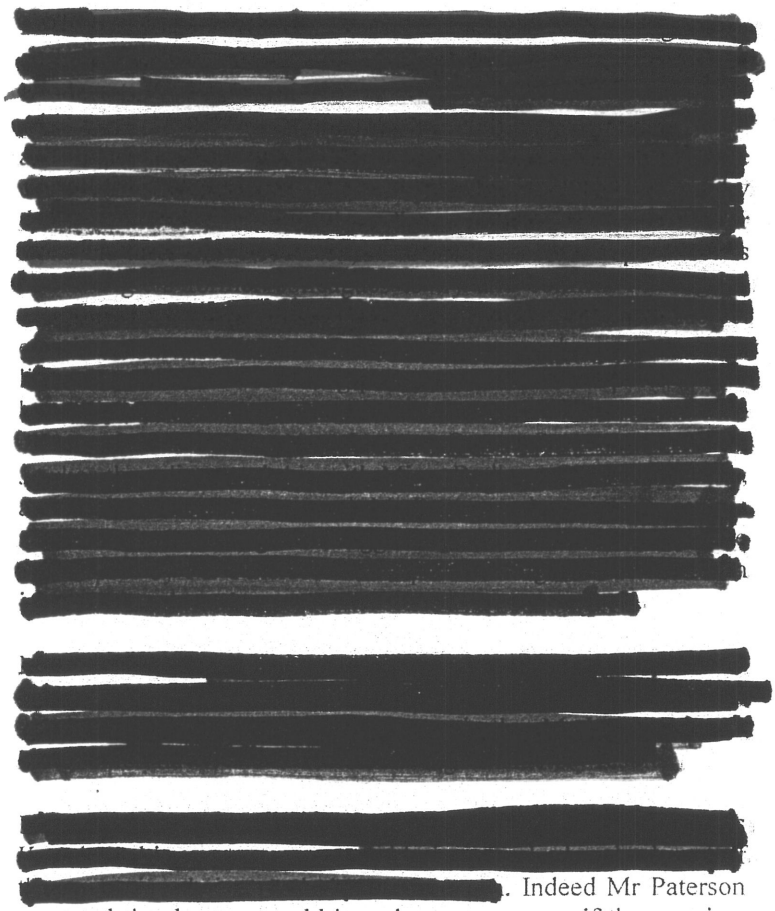
a) **It is alleged that Mr Paterson's inappropriately made contact with a fellow surgeon's ex-colleagues seeking information as to whether there had been any concerns about his performance as a trainee doctor.**

b) **Secondly, it is also alleged that Mr Paterson promulgated inaccurate information concerning the same fellow surgeon's competence to colleagues in person and at MDT meetings resulting in the surgeon feeling professionally undermined.**

Evidence

From the interviews conducted it is clear that Mr Paterson did make contact with ex-colleagues of Mr Ingle seeking information as to whether there had been any concerns about his performance and Mr Paterson accepts that this was wrong and has apologised for doing so. Indeed Mr Paterson felt he had apologised to Mr Ingle when he met with him "to clear the air" as was detailed in Mr Ingle's notes from their meeting of 3 July 2007.

It is also clear from several of those interviewed that Mr Paterson promulgated his concerns about Mr Ingle in person and that he did mention them at MDT meetings (MB, AJ, BS, HI and IP). The latter is clearly not appropriate although Mr Paterson would claim that the information promulgated was not inaccurate and that when he spoke to Mr Bala and Mr Jewkes in person he was simply passing on the information to his line management in keeping with the whistle-blowing policy.



. Indeed Mr Paterson accepted that he too would have been very upset if the enquires had been made about him, and that he had probably done wrong in making these enquires without approval from the Trust and he said he was sorry for doing so.

Then opportunistically in early 2007 some of Mr Paterson's patients presented with disease recurrence. According to Mr Paterson this allowed Mr Ingle to make what he sees as a "tit for tat" complaint against him. The oncologists (IF and AS) who had both raised concerns about the clinical competence of Mr Paterson a few years earlier, came up with current and historical examples of these concerns as they felt this problem had not been

adequately addressed when raised previously. They agreed that whilst Mr Paterson's behaviour in MDTs had changed somewhat for the better following their earlier complaints; they did not feel that the improvement necessarily extended to his surgical practice.

Findings

From these interviews it has become clear that there have been problems within the Breast Services Unit for several years both regarding Mr Paterson's behaviour and regarding his clinical competence and some of these concerns had been raised previously (MB, IF, BS, AS, CF, MaW, MW, CB, BT) . Several of those I spoke to reported that the Breast Surgery Team is dysfunctional, with the Consultant staff working individually rather than as a team. This is not a new situation; but it is recognised that this approach is becoming increasingly unsustainable and inappropriate with the current trend towards team working.

Historically Mr Paterson has been domineering in MDT's with reports of distress caused to a pathologist – [redacted]. These were reported particularly by the oncologists who felt that this behaviour was inappropriate. When these concerns were raised (indirectly) with Mr Paterson it is reported that his behaviour improved. Indeed Dr Fernando, Stockdale, Fletcher, Wallis and Mr Wake all confirm that they felt Mr Paterson's behaviour in the MDT had improved following the concerns raised in 2003.

Dr Stockdale mentioned that at times in the past he had felt bullied professionally by Mr Paterson and Dr Fletcher reported he had felt pressured. Both reported that they have had to stand their ground and that Mr Paterson is now better than he was a few years ago.

Virtually everyone reported that Mr Paterson is an extremely hard working surgeon who has understandable pride in the breast care service that he provides for both his NHS and private patients.

The investigation highlighted that Mr Paterson is not a good team player; but he maintains his priority is to provide a patient focussed service. He sees himself as the patient's advocate (both within the MDT and out) pushing for a good cosmetic result from surgery as well as an effective treatment. Mr Ingle takes a view which is supported by the oncologists that curing the patients' cancer is paramount with the cosmetic outcome although important being secondary.

Several of those I spoke to (MB, IF, AJ and MW), reported that the former breast surgeons John Taylor and Millie Bello both left the Trust at least in part due to difficulties working with Mr Paterson (this is only second hand information as I have not spoken to either of them directly). Subsequently the department was very stretched with Mr Paterson working with the support of locums to maintain the breast cancer service within the Trust.

Mr Paterson was wrong to seek information about Mr Ingle in the way he did and this was not in keeping with any Trust policy or procedure. Mr Paterson was also wrong to mention his concerns in the open forum of the MDT.

I conclude that the complaints into the personal conduct issues were both substantiated.

5. Interim Action

In view of the seriousness of the conclusions reached by Mr Hennessy's interim report with regard to Mr Paterson's clinical competence, it was clear that the Trust needed to take urgent action, subject to completion of the full investigation. The action taken was firstly to protect patients, and also in the best interests of Mr Paterson and of course the Trust whilst these issues were being investigated further. The Interim Report on the Trust's Breast Care Services was therefore produced (Appendix 3).

Following receipt of the interim report, a meeting was convened on 19 December to confirm to Mr Paterson and Dr Connell, his MDU representative the interim action the Trust had decided to take. Ian Cunliffe, Case Manager and Medical Director Surgery, Mark Goldman, Trust Chief Executive and Claudette Asgill, Interim Head of HR Consultancy were also present at this meeting.

Mr Paterson was informed that with immediate effect, the Trust required him to:

- Cease sub-total mastectomy, cleavage-sparing mastectomy and shavings with mastectomy, unless previously agreed with the MDT or if clinically necessary during surgery.

- Demonstrate his technical ability to carry out a total mastectomy to a satisfactory standard by allowing Alan Jewkes, Consultant Surgeon to observe him carrying out these procedures on a minimum of five patients.

- Work constructively with the MDT, ensuring all cases go through the MDT and are fully discussed and consensus opinion followed.

That the Trust would also put in place a new independent chair to ensure consensus view. And that a letter would be sent to other hospitals in which in which Mr Paterson

undertook work outlining the Trust's actions in regard to the practice as detailed above.

Mr Paterson signed to confirm his acceptance of these interim measures.

6. Conclusions

Overall, from the findings from the investigation, including the clinical review, it is clear that there are justifiable concerns with regard to Mr Paterson's clinical practice surrounding his mastectomy technique and also his personal conduct in regard to Mr Ingle and the breast MDT.

Initially I had serious concerns around the care of the male patient seen privately by Mr Paterson both regarding his clinical care and what surgical procedure was actually recommended; and from the reported explanation by Mr Paterson that the confusion was due to an administrative error. This was in keeping with comments from Mr Hennessy and Mr Ingle, neither of whom will presumably have seen the letter from Mr Paterson to the patient's GP, which has recently appeared in his medical notes. This letter does confirm Mr Paterson's view that he was not planning a mastectomy for this patient and so this complaint is not substantiated

The conclusions reached by Mr Hennessy with regard to Mr Paterson's mastectomies are that the "concerns about excision margins and risk of recurrence are in *Mr Hennessy's* opinion justified." Mr Hennessy continued "concerns about the risk of recurrence have not been alleviated since the audit in 2003;" although it was as a result of this audit that Mr Paterson introduced the practice of taking shaves. As Mr Hennessy commented that "the practice of mastectomy shaves seems to add to the concerns regarding this issue". These issues are being addressed by the interim action taken to change Mr Paterson's practice as detailed in Section 5 above.

In summary for the three clinical complaints; I conclude that the first has not been substantiated, whilst the next two complaints have been substantiated.

Mr Hennessy also felt "there are clearly faults within the team and within the organisation in not addressing these concerns". I would agree that the MDT has clearly not helped and indeed most of those interviewed raised concerns about the MDT with several witnesses reporting that they felt it was dysfunctional. It was reported that the "MDT process was to some extent being circumvented and for some of the cases inappropriate decisions were being taken" (Appendix 5 CH's Report).

Several witnesses I interviewed stressed that Mr Paterson's behaviour within the MDT had improved following earlier criticism; and that Mr Paterson "continues to carry out a very substantial volume of the cancer work within the unit" (Appendix 5 CH's Report).

All the clinicians I interviewed seemed to accept the importance of the MDT which suggests that with appropriate leadership and support this could be the key to markedly improved working within the Breast Surgical Unit. Also with three surgeons

working within the unit there is scope for appropriate pooling and greater sharing of the workload.

I would agree with Mr Hennessy that "it should be possible to repair the fractured relationships within the MDT. This would be in the best interest of the Unit, the Trust and more importantly of the patients."

From my investigation into Mr Paterson's personal conduct with regard to his enquiries into Mr Ingle's training, the evidence shows that Mr Paterson's actions were inappropriate and indeed Mr Paterson admitted he was wrong to act as he did.

In conclusion, I believe the complaints into the personal conduct issues were also substantiated.

I believe it should be possible for Mr Paterson to work to address these issues as Mr Hennessy's report mentions that "Mr Paterson indicated that ... if the investigation was to indicate a problem with his surgical practice he was prepared to change his practice".

Similarly from the interview I conducted with Mr. Paterson he maintained he would modify his behaviour and clinical practice if ever it was shown that this needed to change. Indeed Mr Paterson claims he did change his practice when the concerns about his high recurrence rate after wide local excision were raised; he then began taking shavings, with a subsequent lower recurrence rate; this change in practice was confirmed by comments from Dr Wallis.

7. Recommendations

Having considered all the relevant issues and specific examples of the evidence presented, including recommendations from the clinical review undertaken by Mr Colm Hennessey, I recommend the following:

1. A thorough review of the MDT needs to take place involving all members of the team, reviewing data and functioning within the unit.
   This recommendation is already in progress.

2 The practice of shaves at mastectomy should cease. The MDT needs to be confident that a mastectomy means as close to 100% as possible of the breast tissue is removed. Mr Paterson should "cease sub-total mastectomy, cleavage-sparing mastectomy and shavings with mastectomy, unless previously agreed with the MDT or if clinically necessary during surgery." Mr Paterson has already agreed this, and he has also agreed to demonstrate his "technical ability to carry out a total mastectomy to a satisfactory standard by allowing an independent, Consultant Surgeon to observe him carrying out these procedures on a minimum of five patients".

3. The dysfunctional relationships within the MDT need to be repaired. A successful outcome is only likely to be achieved through significant compromises. It is possible that some improvement can be achieved through facilitated meetings.
   Processes to address this have already begun and Mr Paterson has agreed "to work constructively with the MDT, ensuring all cases go through the MDT and are fully discussed and consensus opinion followed."

4 The leadership within the MDT needs to have the support and strength to deal with the difficult situations encountered.
   This has been addressed with a new independent chair for the MDT having been put in place to try to ensure a consensus view prevails.

5 Reconstruction decisions should be taken to the MDT.
   As mentioned above Mr Paterson has agreed to ensure all cases go through the MDT and consensus opinion is followed.

6 The WMCIU data should be reviewed with regard to margins of excision and shaves. It may require going through the histology reports. Data relating to those with recurrences and those identified as having a second or subsequent operation after mastectomies should be reviewed.

   The Breast MDT should be asked to review the management of all patients with breast cancer who have disease recurrence after what was believed to be curative treatment. The size and location of cancers and whether or not there was multifocality should be considered.

   Indeed every cancer MDT within the Trust should be encouraged to do this, if they are not doing so already.

   This should start as soon as reasonably practicable.

7 The notes for all patients of Mr Paterson's who have had sub-total mastectomy, cleavage-sparing mastectomy and shaves with mastectomy, should be reviewed, audited and if necessary given further treatment.

8 A detailed review should take place of immediate reconstructions over the past 3 years.

9 A database for all patients undergoing breast cancer surgery should be set up or adapted to allow ongoing, continuous audit of patient outcomes. All of those treating patients should be encouraged to include patients seen privately on the same database.

10 Treatment policies relating to breast cancer, including mastectomy, excision margins, reconstruction and neo-adjuvant therapies should be formally agreed by the MDT. These policies should be presented in an annual audit.

11 Ensure that appropriate guidelines are agreed to allow the MDT to make decisions about which patients are suitable for primary and secondary breast reconstruction; and ensure the appropriate distribution of this workload.

12 Work is needed to improve the relationships both within the Breast MDT and in the team generally. Everyone involved accepts that things need to change which improves the likelihood of a successful outcome.

13 A facilitated mediation session between Mr Paterson and Mr Ingle should be helpful to them both and to the wider Breast Unit.

14 Mr Paterson was wrong in making enquires about Mr Ingle in the way he did and he accepts this. The Trust needs to make it clear to Mr Paterson that such behaviour is not acceptable and will not be tolerated.

Dr Rex J Polson
April 2008