

PRIVATE AND CONFIDENTIAL



**THE ROYAL COLLEGE OF SURGEONS OF ENGLAND
INVITED REVIEW MECHANISM**

AN INVITED REVIEW REPORT ON BEHALF OF:

**THE ROYAL COLLEGE OF SURGEONS OF ENGLAND
35 – 43 LINCOLN'S INN FIELDS, LONDON WC2A 3PE**

**SOCIETY OF BRITISH NEUROLOGICAL SURGEONS
35 – 43 LINCOLN'S INN FIELDS, LONDON WC2A 3PE**

REPORT ON PROFESSOR MUFTAH SALEM ELJAMEL

NHS TAYSIDE

16 – 17 SEPTEMBER 2013

REVIEWERS:

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MS HELEN CARTER, LAY REVIEWER



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1. Background to the review

On 26 June 2013, Dr Andrew Russell, Medical Director at NHS Tayside wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited individual review of Professor Muftah Salem ("Sam") Eljamel, consultant neurosurgeon, in particular to review Professor Eljamel's clinical knowledge, technical skills and judgement as well as his interpersonal skills. This request was considered by the Chair of the RCS IRM and a representative of the Society of British Neurological Surgeons, where it was agreed that an invited individual review would take place. A review team was appointed and an invited review visit was held on 16 and 17 September 2013, followed by an interview with Professor Eljamel on 2 October 2013.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS's review visit between the RCS and the Trust commissioning the review, and were provided to the surgeon that is the subject of the review.

- a) To consider concerns about the clinical work of Professor Sam Eljamel, Consultant Neurosurgeon, with specific reference to:
- Clinical knowledge, skills, surgical competency and clinical decision making
 - Interpersonal skills and communication skills with patients, relatives and colleagues

These concerns were raised following a series of clinical incidents resulting in a high volume of complaints, including some from patients who had already sought a second opinion.

- b) *If applicable:* NHS Tayside would be receptive to recommendations in relation to wider aspects of service delivery and team cohesiveness within the Neurosurgery Department that may emerge from the context of the review.

- c) *If a case note review is required:*

To review 7 specific patient case notes and corresponding complaints where concerns have been raised by patients and NHS Tayside, and to extend this review to additional case notes if deemed appropriate during the review process.

The reviewers will then make recommendations for the consideration of the Chief Executive and Medical Director of NHS Tayside as to:

- whether there is a basis for concern about Professor Sam Eljamel's practice in light of the findings of the review;
- possible courses of action which may be taken to address any specific areas of concern which have been identified.



3. Details of the surgeon being reviewed

Professor Eljamel FRCSEd, FRCSI, FRCS (SN) was appointed at NHS Tayside in 1995 as a consultant neurosurgeon. Between 1995 and 2005 he was an honorary senior lecturer at The University of Dundee and in 2005 was made an Honorary Reader in Surgical Neurology.

His surgical sub-specialties include: spinal surgery, neuro-oncology, skull base surgery and functional neurosurgery. Since 2012 he has been the lead surgeon on the Scottish Adult Neuro-oncology network (SANON) board.

At the time of the review visit Professor Eljamel's practice was being supervised by the Trust's clinical lead for neurosurgery.

There were three other consultant neurosurgeons working alongside Professor Eljamel, they were:

- Mr David Mowle, Clinical Lead
- Mr Eric Ballantyne
- Mr Chris Lim

As well as the consultant team the following staff supported the department:

- Four Middle Grade staff, including one Clinical Fellow and three specialist registrar (SpR) doctors, ST 1 to 3.
- Two Advanced Nurse Practitioners (Band 8a)
- Three Foundation Year doctors

The consultants worked on-call one in four with prospective cover. When on-call there was always Middle Grade staff and Foundation Year doctor cover. Theatre lists and outpatient clinics were assisted by one Middle Grade doctor and outpatient clinics were also sometimes assisted by an Advanced Nurse Practitioner.

4. Royal College Review team

Lead reviewer	Mr Neil Kitchen FRCS
Clinical reviewer	Mr Nicholas Phillips FRCS
Lay reviewer	Ms Helen Carter
A brief biography of each member of the review team can be found at appendix one.	



5. Visit timetable

Monday 16 September 2013

Dr Andrew Russell and Mr Philip McLoughlin	Medical Director, NHS Tayside and Clinical Director for Specialist Services
Mr David Mowle	Clinical Lead for Neurosurgery and Consultant Neurosurgeon
Mr Michael Canty	Specialist Registrar in Neurosurgery
Mr Asim Sheikh	Specialist Registrar in Neurosurgery
Mr Eric Ballantyne	Consultant Neurosurgeon
Dr Praveen Manthri	Clinical Lead in Anaesthesia and Consultant Anaesthetist
Mr Gerry Marr	Chief Executive, NHS Tayside
Ms Gillian Costello	Associate Nurse Director, NHS Tayside
Mrs Paola Niven	Senior Charge Nurse, Neurosciences
Ms Samantha Weaver	Advanced Nurse Practitioner in Neurosurgery
Ms Lynne Anderson	Senior Charge Nurse, Neurosurgery Theatre
Mr Musheer Hussain	Consultant ENT Surgeon
Mrs Maureen Lafferty	Clinical Governance Lead for the Surgical Directorate and Consultant Renal Physician
Ms Audrey Warden	General Manager for Specialist Services
Professor Keith Matthews	Professor of Psychiatry and Honorary Consultant Psychiatrist
Dr Avinash Kanodia	Consultant Radiologist

Tuesday 17 September 2013

Mr Chris Lim	Consultant Neurosurgeon
Dr Gavin Main	Consultant Radiologist
Mrs Lynn Smith	Clinical Services Manager, Specialist Services
Ms Ruth Jolly	Charge Nurse, Neurosciences
Ms Tracey Passway	Clinical Governance Team Leader
Ms Alison Moss	Complaints and Feedback Team Lead
Mr Ron Buist	Photodynamic therapy Research Nurse Specialist
Ms Suzanne Sinclair	Clinical Nurse Specialist in Neuromodulation
Ms Catherine Young	Senior Nurse Specialist in Movement Disorders
Dr Robert Swingle	Consultant Neurologist
Dr Ian Morrison	Consultant Neurologist
Mrs Sandra Larkin	Head of Nursing, Specialist Services
Ms Sandra Grady	Personal Secretary to Professor Eljamel
Dr Jonathan Bannister	Consultant in Anaesthesia and Pain Medicine

Dr Graham Leese	Consultant Physician and Endocrinologist
Dr Jonathan O'Riordan	Clinical Lead for Neurology and Consultant Neurologist
Wednesday 2 October 2013	
Professor Sam Eljamel	Consultant Neurosurgeon

No patients were interviewed or examined during the course of the Invited Review visit.

6. Documents reviewed as part of the Invited Review visit

1. Organisational structure
 - 1.1 NHS Tayside organisational structure and surgical directorate structure
 - 1.2 Details of the clinical and non-clinical staff dedicated to the service e.g. titles and numbers
 - 1.3 Details of the cover arrangements for the consultant surgeons
 - 1.4 Relevant protocols and pathways
 - 1.4.1 Scottish Intercollegiate Guidelines Network (SIGN) 122 - Prevention and management of venous thromboembolism
 - 1.4.2 SIGN 110 – Early head injury management
 - 1.4.3 SIGN 104 – Antibiotics prophylaxis in surgery
 - 1.4.4 National Institute for Health and Care Excellence (NICE) Low back pain (early management)
 - 1.4.5 NICE Metastatic spinal cord compression
 - 1.5 Details of operating facilities available to the surgery service the surgeon works in, including the number of theatres used by the service and theatre equipment available
2. Details of Professor Sam Eljamel
 - 2.1 Job plan
 - 2.2 Job description
 - 2.3 Curriculum vitae
 - 2.4 Appraisal documentation and personal development plans
 - 2.4.1 2011/12 Appraisal form 4
 - 2.4.2 2010/11 Appraisal form 4
 - 2.4.3 2009/10 Appraisal form 4 and personal development plan
 - 2.4.4 2008/09 Appraisal form 4 and personal development plan
 - 2.4.5 2007/08 Appraisal form 4 and personal development plan
 - 2.4.6 2006/07 Appraisal form 4
 - 2.5 Records of continuing professional development
3. Details of 12 patient complaints
4. Activity and outcome data
 - 4.1 Neurosurgery inpatient / daycase waiting lists as at end July 2013
 - 4.2 Activity data for the surgeon
 - 4.2.1 Neurosurgery consultant led outpatient activity
 - 4.2.2 Neurosurgery admissions – inpatient/ day case and emergency/

- elective split
- 4.3 Comparative outcome data for the surgeon and their consultant colleagues
 - 4.3.1 Emergency readmissions with 28 days
 - 4.3.2 Patient stays and deaths for neurosurgery consultants, 2011-12 and 2012-13
 - 4.4 Details of any databases that the surgeon submits to and information available from this
 - 4.5 Theatre lists from 4 March 2013 to 24 June 2013
 - 4.6 Statistics by speciality/consultant – 01/11/2011 to 31/10/2012
 - 4.7 Statistics by speciality/consultant – 01/01/2012 to 31/12/2012
 - 4.8 Outpatient referrals – M S Eljamel
 5. Multi-disciplinary team (MDT) Audit and Morbidity and Mortality (M&M) data
 - 5.1 Arrangements in place for MDT meetings, M&M meetings and clinical audits and meetings
 - 5.2 Register of attendance Neuro Onc MDT – 11 November 2011 to 12 July 2013
 - 5.3 Minutes of clinical effectiveness M&M meeting – 1 July 2013
 - 5.4 Minutes of clinical effectiveness M&M meeting – 23 May 2013
 - 5.5 Minutes of clinical effectiveness M&M meeting – 24 April 2013
 - 5.6 Agenda of deep brain stimulation MDT meeting – 14 May 2013
 - 5.7 Morbidity and mortality audit meeting - 1 to 31 January 2011
 - 5.8 Morbidity and mortality audit meeting – April 2012
 - 5.9 Global trigger tool audit – April 2012
 - 5.10 Scottish audit of surgical mortality individual annual report – 2009
 6. Supporting documents provided by the surgeon
 7. Letter dated 22 August 2013 from Professor Eljamel to the RCS
 8. Information provided during the review
 - 8.1 Neurosurgery complaints received since January 2011
 - 8.2 Red, Amber, Green (RAG) grading of 12 patient complaints and grading matrix guide
 - 8.3 DATIX incident report form 5441
 - 8.4 List of junior doctors August 2010 to August 2013
 - 8.5 Copies of Professor Eljamel's response to complaints
 - 8.6 Re-admission data: Stays under Professor Eljamel's care for 2012-13
 - 8.7 Minutes of meeting held between Professor Eljamel, Clinical Director and Associate Medical Director for Professional Governance on 3 June 2013.
 - 8.8 Letter from Medical Director to General Manager and Clinical Director, dated 20 June 2013
 - 8.9 Letter from Clinical Director to Professor Eljamel, dated 21 June 2013
 - 8.10 Letter from Professor Eljamel to Clinical Director, dated 24 June 2013
 - 8.11 Email from Professor Eljamel to Clinical Director, dated 25 June 2013

7. Information reviewed that supports the conclusions reached

The following information represents a summary of the information gathered by the reviewers during the interviews held during the individual review and from the documentation submitted. It is organised under the headings of the themes that emerged. In some circumstances the information presented reflects the viewpoints of those individual staff members being interviewed; it does not necessarily reflect the views of the RCS or its reviewers on these circumstances.

Background information and concerns that led to the RCS invited Individual review

Between the start of January 2013 and the invited review visit held on 16 and 17 September 2013 eight patients complaints relating to Professor Eljamel's practice were received by the Trust. The number was significantly higher than in previous years (four in 2012 and three in 2011) and there were noticeable themes of poor performance, wrong site surgery, lack of interpersonal engagement with patients and relatives and poor junior staff supervision.

Owing to the concern raised by this pattern of complaints two meetings were held between Professor Eljamel and Mr Philip McLoughlin, Clinical Director for Specialist Services. The second of these two meetings was held on 3 June 2013 and the meeting minutes noted 'that Professor Eljamel had been under significant pressure in recent years'. This was described as being due to 'deterioration in the quantity and quality of junior staff support, an increased throughput of patients and the pressures of Waiting Time Guarantees'. It was also recorded that Professor Eljamel had 'reflected on these factors and has altered his practice significantly' and that 'any other issues would be dealt with adequately within the Appraisal and Revalidation system'.

On 20 June 2013 Mr McLoughlin and Mrs Audrey Warden, General Manager for Specialist Services, met with Dr Andrew Russell, Medical Director. In this meeting the concerns about Professor Eljamel's practice were discussed, including a letter dated 6 June 2013 from a patient, who had previously made a complaint about Professor Eljamel on 5 December 2012, in which the patient indicated she was aware of another patient who had undergone wrong level surgery. At the meeting Dr Russell suggested the Trust commission a review by the Royal College of Surgeons and that a meeting be held with Professor Eljamel to discuss restricting his practice during the period of the investigation.

Mr McLoughlin met with Professor Eljamel on 21 June 2013 to advise him of the decision to commission a Royal College review and that Mr David Mowle, Consultant Neurosurgeon, would supervise his clinical practice during this process. It was agreed that the details of this supervisory arrangement would be agreed between Professor Eljamel and Mr Mowle and that Professor Eljamel would not participate in the on-call rota in the meantime.

The supervisory arrangements proposed were for Professor Eljamel and Mr Mowle to carry

out a joint ward round on Tuesday mornings, Professor Eljamel's regular post-operative and post-on call day, followed by a detailed case based discussion. Mr Mowle stated that he did not believe there was 'any safety issue with Sam continuing his regular on-call duties' and agreed to discuss emergency cases with him during the joint ward round. It was also agreed that Professor Eljamel and Mr Mowle would discuss the cases that were the subjects of patient complaints. These arrangements were agreed by Mr McLoughlin on 25 June 2013.

Terms of Reference bullet point 1:

Clinical knowledge, skills, surgical competency and clinical decision making

Wrong level surgery

The case note review of 14 cases included four cases where Professor Eljamel had undertaken spinal surgery at the wrong level. These included two lumbar laminectomies, a cervical spine disc replacement and a thoracic disc procedure.

The thoracic disc case was passed to Professor Eljamel from one of his colleagues. Following the operation Professor Eljamel informed his colleague that the patient had developed a haematoma and so would need to have a second operation. Sadly the patient, who was an 89 year old male, died of a chest infection following the second operation. Professor Eljamel's colleague found out some time later, through a discussion with a trainee, that in fact the first operation had been done at the wrong level and that this had been corrected during the second operation. This case had been presented by Professor Eljamel at an M&M meeting, but only in regards to the haematoma and not the wrong site surgery. There was also no record in the patient's notes of the first procedure being carried out at the wrong level.

Professor Eljamel commented that it was not unheard of for this procedure to be done at the wrong level, but that he did always try to ensure the correct level operation was performed. He acknowledged that it may well have been that he had only reported the haematoma during the M&M meeting where this patient was discussed and not that he had operated at the wrong level. He stated that in retrospect he should have discussed the wrong level procedure with his colleagues and that he should have documented this in the patient's medical record.

It was reported that this issue, as well as a prior event when Professor Eljamel had been found to be carrying out a private list while on-call at Ninewells hospital, had raised concerns about his probity. One interviewee stated they had seen the private hospital's theatre logs and that in fact there had been numerous occasions when he had undertaken a private list when on call. As a result of the concerns identified by the Trust Professor Eljamel was asked to cease his private practice, which the private hospital was said to have confirmed.

When asked about his approach to dealing with surgical complications Professor Eljamel

conceded that in the past he had dealt with errors 'personally' and that he had not brought these cases to the attention of his consultant colleagues. He stated however that his practice had changed and that he would bring any patient he 'discovered' to have had wrong level surgery to be discussed at the M&M meeting.

The review team also heard about a patient who had been operated on by Professor Eljamel at a local private hospital in April/May 2013. This patient's operation was also said to have been performed at the wrong level and the patient was discharged by Professor Eljamel while suffering from faecal incontinence, with no specialist involvement. The patient was later admitted to Ninewells hospital for further treatment. Details of the operation performed by Professor Eljamel were not available as the work was not undertaken on behalf of the Trust.

Professor Eljamel also discussed his clinical practice with regard to implantation of "X-Stop" spinal devices. He stated that there had probably been three or four occasions out of the approximately 70 of these procedure he had carried out where the operation had been done at the wrong level. Professor Eljamel denied that he had refused to allow registrars into theatre when correcting these procedures, as had been suggested.

Operative technique

Most of Professor Eljamel's colleagues commented that they believed his operative technique was of a high standard, that he generally had good surgical outcomes and few post-operative complications. This was supported by the re-admission data provided by the Trust, which showed that for 2012-13 Professor Eljamel's re-admission rate was 4%, the same as Mr Lim's and lower than that of Mr Mowle and Mr Ballantyne. A number of interviewees stated that they referred patients to Professor Eljamel at least as often as they did to his colleagues, if not more so. One also stated "If you want something done, go to Sam. If you want more conservative management go to one of the others." Professor Eljamel stated that he felt that he was now far more selective about the patients he operated on. He said that in the past he had been overly generous, agreeing to operate where there was perhaps only a 50% chance that the surgery would help the patient.

It was also noted that he was capable of working quickly, but there were differing opinions as to whether this was beneficial. The reviewers heard from different sources that Professor Eljamel's surgical practice was 'very slick' but also that it would benefit from being more patient and that he sometimes 'cut corners'. A number of individuals stated that Professor Eljamel tried to push through as many spinal cases as he could, and that sometimes these procedures were rushed. One interviewee remarked, 'if he wasn't such a good surgeon he would have a lot more complications.' The review team heard that his lists usually included between five and seven cases, regularly overran and that staff found this to be hectic and stressful.

It was reported that Professor Eljamel's practice had slowed down somewhat since the introduction of the World Health Organisation (WHO) checklist, that for a time he had refused to follow it and that he had argued with colleagues about it. It was stated that Professor Eljamel was now compliant with the WHO checklist but that he delegated its completion to a registrar. The review team did not however see any audit data showing his compliance.

Waiting times

The waiting list data provided by the Trust shows that the number of patients on Professor Eljamel's waiting list, 46, was slight higher than his colleagues who had between 15 and 40 patients on their lists. One notable factor was however that on average Professor Eljamel's patients had waited a lot longer for their procedures. Of the 27 neurosurgery patients who had waited more than 84 days 24 were patients of Professor Eljamel. During the interviews when his colleagues were asked about this, they explained that they did not know why Professor Eljamel's patients experienced longer waiting times for surgery. It was stated that Professor Eljamel had made some progress in reducing the number of long waits, by carrying out extra theatre sessions and that his consultant colleagues had also helped by taking on a few of his patients.

Professor Eljamel explained that he believed waiting times were one of the factors that had contributed to the increase in his complaints. He described that in one of the complaints seen by the review team that the patient had had to wait for three weeks to be seen in the clinic following their operation. Professor Eljamel said he believed that the length of time patients had to wait for a post-operative clinic appointment was getting out of hand and that the Waiting Time Monitor was only interested in waiting times for new patients.

He also reported that he had taken on more responsibilities and more patients over the years and that he had done this to try to be helpful. He reported that recently he had tried to make more time available by giving up a number of commitments including his pain clinic, his membership of the NHS Tayside ethics committee and his private practice, which he stated had ceased on 21 June 2013.

There was some speculation that the amount of study leave taken by Professor Eljamel could have contributed to his waiting list figures. The review team heard however that, although he did take more study leave than others and that all but one monetary withdrawal from the department's endowment fund had been made by Professor Eljamel to help his studies, on balance he did not take an excessive amount of study leave given his academic interests. No actual data to support this was provided to the review team.

Pre-operative and post-operative care

During the interviews concerns were raised about Professor Eljamel's pre-operative and

post-operative care. The review team heard that Professor Eljamel did not follow the local protocol regarding operative spinal level marking and that instead he just palpated the patient's spine to attempt to determine the correct level. Professor Eljamel also confirmed that there was no pre-operative skin marking for spinal or cranial cases on the ward and that he was not aware this was done by anyone in the department.

Concerns were also raised about Professor Eljamel's approach to continuity of care and it was stated that there had been occasions when he had gone away without handing over his patients to a Consultant colleague.

The case of an 18 month old patient was described. The patient was admitted on a Monday and on the Wednesday Professor Eljamel was asked to see the patient, who was waiting to be transferred to another hospital, that day. However, by the end of the week the patient had still not been seen, and it was commented that this was because Professor Eljamel did not regard this child as his patient.

Supervision and delegation to junior colleagues

The case note review showed that in a number of cases Professor Eljamel had not sufficiently supervised procedures performed by junior colleagues. This included an elderly patient with lumbar spinal stenosis who also had motor neurone disease and a number of comorbidities. Another case involved a patient with lumbar radiculopathy, who was unable to have magnetic resonance imaging due to a having pacemaker and had to wait for a myelogram. The patient pathway and experience would have been improved with more senior intervention and leadership.

The review term also heard about Professor Eljamel's delegation of clinics to junior Neurosurgeons. It was described that he would screen the patient's clinical record and give a management plan for each one. The registrar would then carry out most, if not all, of the clinical consultations including new as well as follow-up appointments. If the registrar felt they needed assistance, Professor Eljamel would agree to see the patient, although it was reported he sometimes needed to be asked more than once. When he was away his clinics would proceed without supervision. Professor Eljamel's estimation was that he previously saw between one third and one half of patients in clinics.

Professor Eljamel also explained that he had previously delegated the process of obtaining consent from patients during pre-operative ward rounds to the registrars as well as the responsibility of making entries into the patient's medical records.

Professor Eljamel stated that he felt the standard of junior staffing within the department had declined and that this was another factor that had contributed to the level of complaints that he had received. He said that the recruitment of juniors needed to change and that the department needed ST3s and 4s rather than ST1s and 2s.

Terms or Reference bullet point 2:

Interpersonal skills and communication skills with patients, relatives and colleagues

Communication with patients and relatives

Interviewees had divergent views about Professor Eljamel's communication with patients. Some felt that he had good clear communication, that patients praised him and that his approach to consenting was appropriate as he described the potential risks and complications. They also stated that he had been good at communicating with patients and relatives following a bad outcome to a procedure.

Others however had opinions that were entirely opposed to these, stating that Professor Eljamel had given patients incorrect information, that some patients had difficulty understanding him, that he sometimes exaggerated the benefits of surgery and that he struggled to deal with patients who were not happy and as such he had apparently gone out of his way to avoid them.

The review team heard from a number of sources that communication was a weakness of Professor Eljamel's and in particular that he was sometimes short with patients, which could make him appear dismissive. He was described as being 'not the sort of doctor to draw up a chair and sit and talk to a patient. He stands at the end of the bed and says what he wants to say and not much else.' The result of this was that patients felt that they were not given as much time as they needed and that sometimes Professor Eljamel would cut the consultation off abruptly, saying 'that's it, we're done here'.

Professor Eljamel explained that it had not been his intention to not listen to patients but that he did not feel the ward round was the right time to sit and talk to patients for confidentiality reasons. He said he did not feel comfortable discussing a patient's condition in front of others, but that there was not really any other space available.

It was also stated that Professor Eljamel found it difficult to communicate with patients that were disappointed with their surgical outcome and that at times he came across as being defensive. It was stated that he was less good when following up with a patient, than when he was seeing new patients. Professor Eljamel stated that in the past he may have avoided patients that had had bad outcomes but that this had not been his intention.

Another theme which came out was patients' dissatisfaction with how accessible Professor Eljamel was. Some patients attended clinics expecting to see Professor Eljamel as he had told them as much in a letter. When they saw the registrar instead these patients were unhappy and would often request to see Professor Eljamel in person, which was not possible on occasions when he was away during his clinics. There were also concerns about Professor Eljamel's lack of visibility on the ward, with patients again requesting to see him rather than a junior doctor. Regarding one of the complaint cases Professor Eljamel explained that he

had been in the department between 11am and 1pm on the Sunday before the patient's operation but that, because of the Trust's staggered admission policy, the patient had not been admitted until 3pm.

Some of the interviewees remarked that at times it was difficult to locate Professor Eljamel or to convince him to see a patient. Other interviewees did however state they did not have difficulty contacting Professor Eljamel on his mobile phone and that they would arrange a time to see him later on and that he would honour these appointments.

Professor Eljamel said that patients had often called to try to speak to him before they made complaints and that in the past these calls had not always been handled very well. He suggested that secretaries should be provided with training on how to deal with these calls. He also explained that in the past he had been reluctant to talk to patients over the phone for reasons of confidentiality but that he now did this in an attempt to reduce the chance of complaints.

Working with colleagues

There were very divergent views from Professor Eljamel's colleagues regarding their experiences working with him. A number expressed that they get on well with him and had not had any difficulties working alongside him. It was said that he could be helpful when someone needed to swap rotas around. Some of the interviewees felt he was as approachable as the other consultant Neurosurgeons and that he treated them as an equal. Professor Eljamel was said by some in this group to be no more domineering than the other Neurosurgeons, while others admitted that he could sometimes be unreasonable. It was felt that Professor Eljamel could be charming at times, but that this seemed to be in service of his own needs and it was unclear if this was genuine.

Some of Professor Eljamel's colleagues stated that they had satisfactory professional relationships with him, but that he was 'not my favourite colleague' and that he could be difficult to work with. It was noted that he could be defensive and that his behaviour did not encourage open discussions making conversations with him uncomfortable. An example was given of Professor Eljamel being obstinate when challenged over wearing a watch and not complying with guidelines on being bare below the elbow.

Others explained they had had less positive experiences working with Professor Eljamel. He was described by some as being intimidating and examples were given of him shouting at colleagues or putting them under unreasonable pressure to complete tasks for him. Professor Eljamel was described as having high standards and being intolerant of mistakes. Some interviewees described that they felt they had been bullied and that they had colleagues who felt similarly. The review team also heard from some interviewees that they had colleagues who did not enjoy working with Professor Eljamel and in some cases that they had refused to work with him. It was said by some that he had a reputation throughout

the hospital for being difficult to deal with.

His own perception was that his relationships with other staff were 'collegial' and that he did not believe he was abrasive with anyone. He did say that he had bad days as well as good and that he was softly spoken so that when he raised his voice to be heard better that this might be perceived by some as him shouting.

During the interviews a number of individuals stated that they viewed Professor Eljamel as being 'old-fashioned' in his attitude. This included that he perceived himself as being the lead consultant, based on seniority, that it was 'his operating theatre' and that he had his own anaesthetist. Professor Eljamel stated that he tried not to schedule complex cases when Dr Manthri was away as he was the anaesthetist he worked with most of the time. He stated however that there were no problems with him working with any of the other anaesthetists.

There were also concerns about Professor Eljamel's collaboration with his colleagues and it was said that he did not effectively utilise his team and that seemed to feel he was on his own. The review team heard that he refused to go the Paediatrics department to see his patients, that he had only recently started going to the intensive therapy unit (ITU) and that he refused to refer his patients to the pain clinic owing to a previous disagreement. Professor Eljamel reported that he had no problem working with the pain service, that he did refer his patients to them and that he had previously held a concurrent clinic with them.

Many of the interviewees stated they were aware that there were difficulties between Professor Eljamel and his consultant Neurosurgeon colleagues. The perception was that the other three consultant Neurosurgeons got on well, but that they were not friends with Professor Eljamel. This was an opinion shared by Professor Eljamel who stated, 'I am not close friends with them' but that he did discuss cases with his colleagues in meetings and would refer patients to them.

Dealing with junior colleagues

A theme that emerged from the interviews was of colleagues who had found Professor Eljamel more difficult to approach when they had started at Ninewells hospital, but whom now found this easier. Some of the more senior members of staff said they felt confident enough to challenge him but that their more junior colleagues had reservations and were more likely to approach someone else about issues.

Professor Eljamel stated that he did not believe he shouted at trainees in theatre but admitted that if he was dissatisfied with their presentation of a case he might 'tell them off'.

Regarding his work with junior Radiologists, some interviewees noted that junior staff might be intimidated by Professor Eljamel and so less likely to confront him about something the identified in a scan. Professor Eljamel stated that he would always prefer that they report on

any issues they identified when reviewing his patients' scans.

Some interviewees stated they would be willing to send a trainee to speak to Professor Eljamel and that when he delegated work to registrars he was approachable if they required assistance. Others however felt that he did not adequately support trainee Neurosurgeons and that when they required assistance sometimes he would scrub up and come into theatre, but not always. Professor Eljamel explained that in one of the complaints cases he had joined the operation when called by the nurse to assist in repairing a cerebrospinal fluid leak.

It was reported that on some occasions, when approached by a registrar who was in theatre, he advised them to seek assistance from a more experienced registrar rather than assist them himself. He was described as having the opinion that 'it's a teaching hospital; they have to learn from their mistakes.' A number of interviewees reported that on some occasions they had looked for Professor Eljamel, but had been unable to locate him.

Regarding Professor Eljamel's teaching skills, opinions were again divided. Some felt that he provided good teaching and cited that he engaged staff in discussing differential diagnoses for patients during wards rounds. Others however stated that during ward rounds he would provide the same teaching for each group of medical students, but would not excuse registrars who had heard the same information numerous times before. In theatre it was explained that teaching opportunities were limited as his busy operating lists did not afford Professor Eljamel any time for training juniors. The review team heard that he would complete complex procedures himself, leave registrars to complete more simple procedures alone and that he would sometimes call in trainees at night, even though they were not on call.

It was also heard that Professor Eljamel had once signed up to help examine in a clinical skills ward assessment exercise. The feedback from the medical school was that he had been aggressive and would not be welcome back to examine again.

Behaviour in meetings

The Trust submitted copies of the registers of attendance for the Neuro-Oncology MDT meetings held between 11 November 2011 and 12 July 2013. Professor Eljamel's attendance rate for these meetings appeared to be less than 20%. However, it was reported during the interviews that his attendance at MDT meetings was generally good and it was speculated that perhaps it was more a case of him failing to sign the attendance sheet. Professor Eljamel said he attended the Neuro-Oncology MDT meetings whenever he was in Dundee and did not have an operating list on the day of meeting, but that he could not estimate what his attendance rate was.

In clinical meetings such as the Neuro-Oncology and Neuro-radiology meetings Professor

Eljamel was said to participate and be approachable and all of the interviewees agreed that these meetings had an open atmosphere where challenging questions could be asked. However, the review team also heard that when challenged, Professor Eljamel often gave general answers and that it was difficult to get the sort of response that would have been expected. It was also stated that Professor Eljamel had difficulty admitting when he had made a mistake. His own opinion was that these meetings were 'collegial', uninhibited and that he could be challenged by his colleagues.

During the interviews it was reported that the consultant Neurosurgeons had tried to establish a consultant meeting about five years ago, but that Professor Eljamel had said that he did not have time for this. Professor's Eljamel presented a different account, stating that when he was clinical lead monthly meetings were held with the other consultants as well as representatives of the junior staff and of the nurses.

The review team were told by a number of interviewees that in other meetings, such as Clinical Governance meetings that Professor Eljamel was polite and courteous, that he contributed and that other attendees had found his views and experiences very helpful.

Management

Professor Eljamel was described as having an autocratic management style. He acted as clinical lead for approximately ten years and when approached about rotating this role between the other consultants it was said that he was reluctant. He is said to have stated that the responsibility should rest with him as he was the senior consultant and explained there was 'no democracy here'. When the issue was escalated Professor Eljamel agreed to step down from the position. His own account of this was different as he explained he had continued on as clinical lead due to the concerns about external threats to the future of the department and that he had felt a weight had been taken from him when he stepped down from the position. When asked if he felt he was the top man in the department Professor Eljamel responded 'if I was top man I wouldn't be here [undergoing the invited review], that is not my perception'.

There were concerns too about his style of management on the wards. It was reported that there had been a problem, when Professor Eljamel had tried to bring in patients when there were no beds for them. The review team heard that he was not happy if his patient could not be fitted in and would tell ward staff to 'find them a bed'. An example was given of Professor Eljamel asking for a patient to be removed from the high dependency unit (HDU), to make room for a patient of his.

Some of the interviewees also described problems with his recruitment and management of honorary fellows, many of which were said to be of poor quality. These individuals were brought in from European units, who provided funding for their posts, and were personally attached to Professor Eljamel. It was stated that he should not have been solely responsible



for their training and that input should have been sought from the medical school. Professor Eljamel explained that these research fellow positions were advertised as researchers to attract more applicants. He also stated that he had not been solely responsible for their selection as another consultant was involved in interviewing them.

Changes in behaviour

The review team heard that the concerns raised by the pattern of complaints received about Professor Eljamel had affected him and in the words of one interviewee had 'hit him quite hard'. During the interviews it was stated that he had recently realised there was a problem with his practice and that he had insight into where he had gone wrong.

It was explained that in recent months, since the introduction of his supervision, Professor Eljamel's practice had changed and that he now saw all of his patients in clinic. It was also reported that his hand overs were better, his practice was now more patient centred and that his prescribing had improved.

Professor Eljamel gave a similar description of these changes to his practice and said that he had made these in response to the concerns that were raised. He explained he now did intraoperative imaging to ensure the correct procedure was done and that he felt this meant that there would not be any further wrong level operations. His opinion of the supervisory arrangements put in place was that they were unnecessary but that he was willing to abide by them.

There were divergent opinions as to whether Professor Eljamel was capable of sustaining this change. A number of interviewees commented on Professor Eljamel's capacity to change. Some of them stated that they thought he had changed somewhat in the years that they had known him, noting that he was mellower than previously. Others however stated that in the past he had amended his behaviour when under scrutiny, making short term changes, but had not sustained the improvement in the long term. Examples were provided of Professor Eljamel agreeing to changes to improve ward rounds, or to becoming charming after being challenged about the way he had spoken to a colleague. In both cases he was said to have slipped back to an old pattern of behaviour in time. Professor Eljamel stated that he was not aware of having slipped back to old ways and that he could not recall any specific examples of this.

Other issues arising during the review visit

Clinical Governance

Through the course of this individual review a number of issues came to light regarding the clinical governance within the Neurosurgery department and the surgical directorate as a whole.

During the interviews it was heard that there had been problems with Professor Eljamel's

performance in the past but that these had been dealt with informally. It was stated that no documented concerns or formal complaints from other staff about Professor Eljamel's behaviour had been submitted. The reason given for this was that there were concerns about the possibility of a re-structuring of neurosurgical services in Scotland and that any unrest within the department might put it at risk.

The review team were also informed of the current DATIX powered incident and complaints management system, which had been introduced in January 2012. It was stated that this system had helped improve the culture of incident reporting within the Trust, although there were said to still be some departments within the hospital using their own independent system, rather than the Trust wide system. The reviewers heard that some staff had expressed the feeling that reporting took too long and that they did not get enough feedback to warrant input.

It was explained during the interviews that, using the DATIX system, complaints were entered as incidents and that all incidents were coded as; red, amber or green depending on their significance. It was stated that a wrong site surgery would always be coded as red and that red incidents were brought to the attention of the clinical governance team. A summary of the incident reports for each of the complaints relating to Professor Eljamel's practice was provided. Of the four cases in which wrong site surgery had been performed only one had been coded as red. The review team also heard that the Dr Maureen Lafferty, Clinical Governance Lead for the Surgical Directorate was aware of the Serious Clinical Event Analysis (SCEA) of one of the complaints, but did not know which surgeon this concerned and had no knowledge of any of the other complaints until she was invited to attend an interview for this invited review. Dr Lafferty stated that she would have expected a review of the wrong site surgeries to lead to a process that would avoid them recurring, but had not been involved in any such process.

Job planning

There were also a number of issues relating to the Consultant Neurosurgeons' job plans, which were raised during the course of the interviews. The review team heard that the department had taken on a lot of degenerative spinal cases from East Fife, which had added to the surgeons' workload and changed their scope of practice to being predominantly spinal work. Professor Eljamel stated that he felt that his workload was too high and that he had been pressurised to take on more patients and that he now undertook additional evening clinics of six to seven patients all of which were spinal cases.

All four consultants were undertaking some intra-cranial cases and their respective sub-specialties were reported as being: skull base for Professor Eljamel, paediatrics for Mr Ballantyne, vascular for Mr Mowle and complex degenerative spine for Mr Lim. A number of the consultant surgeons who were interviewed stated that it would not be feasible to keep taking on cases from East Fife without additional support. Professor Eljamel said he would

give up degenerative spine work if he could and that he had discussed this informally in the past and had been told that there could not be a neurosurgeon at Ninewells who did not do spinal work. The other three consultants also stated that they felt they would become de-skilled by the likely reduction in the number of cranial cases they saw if Professor Eljamel did give up degenerative spine work.

Another issue was that the Consultant Neurosurgeons' current job plan allocated them to be on the on-call rota on the same day that they had a scheduled theatre list. Some of the interviewees expressed concerns about this system, stating that it was difficult to get hold of the on-call surgeon as the need to scrub up and go into theatre was a barrier to communication with them. Professor Eljamel stated that he felt there was a need to change this arrangement and that it was distracting to be asked questions by the Advanced Nurse Practitioner while operating.

In circumstances when an emergency neurosurgical case occurred while the neurosurgical theatre was in use it was reported that the operation would instead be carried out in a general surgery theatre. This was however contradicted by another account that stated that in acute situations the anaesthetic room was used for procedures. It was Professor Eljamel's belief that additional theatre resources were required.

It was also reported that the Consultant Neurosurgeons had a non-clinical half day when the M&M meeting was scheduled. There were however some clinics scheduled in this time slot and as such it was not possible for all of the surgeons to attend these meetings.

8. Conclusions
Basis on which conclusions are reached
The following conclusions are reached on the basis of the documentation reviewed (as set out in section 6 above) and the interviews held with staff at NHS Tayside (as described in section 5 above).
Overall conclusions about the surgeon under review
The Trust reported that they requested an invited individual review following a cluster of complaints regarding Professor Eljamel. These complaints were centred on his clinical practice, including a number of references to spinal procedures having been performed at the incorrect level, as well as his communication with patients. The review team were made aware that there were also a number of Professor Eljamel's colleagues who reported having difficulty working with him. Having considered the documentation provided by the Trust and Professor Eljamel as well as the information gathered through the case note review and during the interviews the review team found that there was a cause for concern with Professor Eljamel's clinical practice. <u>Wrong site surgery</u> Of the fourteen patient records that were provided by the Trust for review, four cases included wrong level procedures having been carried out by or under the supervision of Professor Eljamel. All of these cases were related to patients with degenerative spinal conditions. Professor Eljamel also stated that he was further aware of 'perhaps three or four' X-Stop spinal devices which he had initially implanted at the wrong level out of a total of approximately 70 cases. Based on the information that the review team gathered these errors appear to be the result of Professor Eljamel's failure to appropriately mark the correct operative level. He insisted that his practice had now changed and that he was using intra-operative imaging to ensure that spinal operations were done at the right level. He was however still not using pre-operative marking, he insisted that this was not done in the department (although this was reported to be the case) and appeared surprised to hear that this was widespread standard practice in the UK. Another relevant factor may have been Professor Eljamel's approach to a relatively high workload of degenerative spinal cases. During the interviews Professor Eljamel was described as having scheduled long, full lists which he worked through quickly and there was the suggestion from some that he perhaps rushed through some of these cases. This

workload had been increased by the Trust taking on more cases from outside of its established catchment area, including parts of East and South Fife.

Openness with colleagues

At least one of the four wrong site surgeries was presented at an M&M meeting without Professor Eljamel discussing that he had performed the procedure at the incorrect level. He stated that his approach had been to correct errors 'personally' and admitted that there had been occasions in the past when he had been less than entirely open with his Neurosurgical colleagues. When asked about Professor Eljamel's attitude in meetings his colleagues noted that it was often difficult to get the answer they were looking for from him.

This lack of transparency raises concerns about Professor Eljamel's probity.

Team working

Not all of Professor Eljamel's colleagues found it possible to work collaboratively with him and a number of the interviewees reflected that he was difficult to approach due to his interpersonal style.

Although a number of his colleagues reported having no difficulty working with Professor Eljamel and that he treated them as an equal, others stated that they found him intimidating, that they did not like working with him and that others refused to work with him at all. Professor Eljamel acknowledged that he was not friends with the other consultant neurosurgeons but described his professional relationships with them as 'collegial'. Outside of the department it was widely understood that there were difficulties between Professor Eljamel and the other neurosurgeons.

One theme that emerged was that the consultants who worked with Professor Eljamel in undertaking his specialist work, including skull base, deep brain stimulation for movement and other functional disorders including obsessive compulsive disorder (OCD) had more positive experiences working with him than his consultant Neurosurgeon colleagues did. These areas of specialist work involved relatively few cases, received a lot of multi-disciplinary support and appeared to be the areas of practice that Professor Eljamel was most interested in. The bulk of his neurosurgical work was however comprised of degenerative spine cases, which Professor Eljamel admitted he had attempted to give up in the past.

Another consistent theme was that colleagues who had worked with Professor Eljamel for a long period of time found him easier to confront when necessary. A number explained that they had found him difficult to approach at first, but that over time they had felt more comfortable with this. More junior colleagues of Professor Eljamel's, including surgical trainees were said to find him intimidating and unlikely to approach him about difficult

issues. There were also those who felt he had bullied them, by shouting at them in front of colleagues or patients.

Supervision of junior colleagues

Professor Eljamel appeared to have delegated a lot of his responsibilities to junior colleagues, which may have been a contributory factor in a number of the complaints received. He operated clinics in such a way that trainee surgeons saw most, if not all of his patients and it was stated that he sometimes needed to be asked more than once to see patients when required. Even when Professor Eljamel was away from the hospital his clinics went ahead as normal and he did not arrange for another consultant to supervise the trainees seeing his patients. Although this was his arrangement for new as well as follow-up patients, Professor Eljamel was described as being especially unlikely to see patients who had come for follow-up appointments following surgical procedures.

Trainee surgeons were asked by Professor Eljamel to undertake a number of his routine spinal procedures without supervision. In situations where the trainee felt they required Professor Eljamel's assistance there were some examples given of him not being contactable during the procedure or being unwilling to scrub up to join in. On occasion he advised trainees to contact another, more experienced trainee for assistance rather than providing this himself. During the interviews it was reported that there had previously been occasions on which the reason Professor Eljamel was unable to be contacted was that he was performing a list at the private hospital in Dundee.

The impression that these accounts gave was that the care provided to Professor Eljamel's patients was not consultant led. In some cases a patient may have been seen pre- and post-operatively and had their procedure performed by different trainees, with little direct involvement from Professor Eljamel. The case note review showed that in a number of cases Professor Eljamel had not sufficiently supervised procedures performed by junior colleagues, which was likely to have affected the care the patient received and led to the complaint being made.

When asked what had led to the cluster of complaints which had caused concern about his practice Professor Eljamel cited degradation in the quality and quantity of junior staffing. He did not acknowledge that his lack of involvement could have been a contributory factor. His insistence of the need to recruit more senior trainees might cause a concern that his intention would be to again delegate a significant proportion of his work to them.

Communication with patients

Professor Eljamel's ability to communicate with patients was seen by some of his colleagues as a weakness and there were accounts of him not being accessible enough to patients.

There were widely divergent opinions about Professor Eljamel's communication with patients. Some of his colleagues felt he took consent from patients appropriately while others felt he overstated the benefits of surgery. The review team heard from some that he was good at explaining to patients about bad outcomes, while some others stated that he found it difficult to communicate with patients that were disappointed with their surgical outcome and that he would avoid these patients during ward rounds.

A number of Professor Eljamel's colleagues expressed the view that communication with patients was one of his weaknesses. They stated that he could come across as being dismissive of patient's concerns, which was a theme that came up in some of the patients' complaints.

Professor Eljamel's patients were much more likely to see a trainee surgeon in one of his clinics than they were to see him. On occasion he was said to have sent letters to patients stating that he would be there to see them in person and so when this did not occur the patients were understandably dissatisfied. Those that requested to see Professor Eljamel were reported to sometimes find that he was either away or refused to see them, despite what he had said in his letter.

Professor Eljamel observed that patients would often try to call him to discuss issues prior to them making complaints. He explained that in the past he had been reluctant to talk to patients over the phone for confidentiality reasons. A small number of the complaints that were looked at by the review team may have been avoided if Professor Eljamel had made more time to meet with the patient to discuss their concerns.

Recent changes

In response to the concerns that had been raised the Trust put in place supervision of Professor Eljamel's practice, which consisted of joint ward round and subsequent discussion with the clinical lead for neurosurgery.

Professor Eljamel stated that the concerns had also prompted him to make a number of changes to his practice. This included undertaking his own clinics, personally consenting his patients during ward rounds, conducting his own procedures and making entries into patient records himself. He also stated that he would now bring any wrong site cases to the M&M meeting for discussion.

The review team did however hear of previous occasions when Professor Eljamel's behaviour had been forced to change. Interviewees described that in these instances he had slipped back to an old pattern of behaviour over time. This led some to doubt whether Professor Eljamel was capable of sustaining the recent improvements he had made in the long term. The review team heard the opinion that Professor Eljamel's practise over the last 10 to 20 years was 'finally catching up with him', with regard to the concerns that had been

raised.

Wider issues

Although the Trust specifically requested an invited individual review of the performance of Professor Eljamel, the terms of reference also included 'wider aspects of service delivery and team cohesiveness within the Neurosurgery Department'. As such the following conclusions have been prepared based on the information that was provided during the interviews.

Clinical governance

The Clinical Governance Lead for the Surgical Directorate had limited knowledge of the concerns that had been raised and until shortly before being interviewed did not know which of the four neurosurgeons the concerns related to. There appeared to be some lack of clarity around the purpose and associated responsibilities of this position and whether sufficient time was allocated to these.

A number of the interviewees described having previously had concerns about Professor Eljamel's practice but that they had not addressed these formally due to concerns about external threats to the future of the department. This approach may have caused a delay in addressing the deficiencies in his practice.

Job planning

The review team heard that the neurosurgical department had taken on a lot of degenerative spinal cases from East Fife, which had added to the surgeons' workload and changed their scope of practice to being predominantly spinal work. Professor Eljamel said that he felt that his workload was now too high and all of the surgeons agreed that this increase could not continue without the provision of more support.

Professor Eljamel also stated that he would prefer to give up degenerative spine work if he could and that he had discussed this informally in the past. The other three consultants expressed concerns about such an eventuality, as they felt it would limit the scope of their practice and cause them to become de-skilled.

Concerns were also raised about the on call rota, which scheduled the consultant surgeon who was in theatre to also be on call at the same time and during the evening following their operating list. There were some reports that this arrangement made it difficult to get hold of the on-call surgeon and Professor Eljamel expressed that it was distracting to be asked questions while operating. There was also no clear answer given as to what would happen if an emergency case was admitted while the on call surgeon was in the middle of a long complex operation on their list. As such the on call rota arrangements in place did not appear to be appropriate.



In a situation such as this it was not clear where an emergency neurosurgical operation would be carried out. Some interviewees stated this would be done in a general surgery theatre, while other explained that these theatres were not appropriately equipped and that in the past the anaesthetic room had been used. It was Professor Eljamel's belief that additional theatre resources were required.

M&M meetings were scheduled when the Consultant Neurosurgeons had a non-clinical half day. There were however some clinics scheduled in this time slot and as such it was not possible for all of the surgeons to attend these meetings. This seemed to be an inappropriate scheduling of clinics during what was intended to be the consultant's protected time.

9. Recommendations

The following recommendations are for NHS Tayside to consider

Recommendations provided immediately following the review visit

Following the interview with Professor Eljamel, the Royal College wrote to the Trust on 4 October 2013 to recommend that supervision of Professor Eljamel's spinal surgery continue, pending the completion of the review report, ensuring that:

- He follows departmental guidelines for pre-operative marking.
- All of Professor Eljamel's spinal cases receive post-operative imaging to ensure procedures have been performed successfully and at the right level.
- All of Professor Eljamel's cases are subsequently audited.

It was also recommended that a review of Professor Eljamel's spinal surgery cases be undertaken to ensure there were no wrong site surgeries that have gone unaddressed. An appropriate timescale for this review would be for the past three years, unless problems are found to have been evident for longer, in which case the scope should be extended. If any additional wrong site surgery cases were identified the patients in question would need to be:

- Reviewed to allow consideration of the benefit of further treatment.
- Informed of the issues identified with the care they had previously received.

Prioritised patient safety actions for the Trust

Given the significance of the performance issues identified, which included a number of wrong site procedures, and the concerns raised regarding Professor Eljamel's professional behaviour, including a lack of openness with his colleagues, the Trust should now take steps:

1. To share the concerns raised about Professor Eljamel's capability and conduct as set out in this report with the Trust's General Medical Council (GMC) Employment Liaison Adviser. This is to allow the GMC to consider these matters further and instigate any action they deem necessary to consider Professor Eljamel's ongoing fitness to practise.
2. To further investigate the concerns raised regarding Professor Eljamel's lack of openness with his colleagues and through this investigation to determine whether or not he had taken consent appropriately from patients when re-operating on them to correct previous wrong level operative procedures.

When acting on the above recommendations, the review team considered that it would also be appropriate for the Trust to:

3. Meet with Professor Eljamel to explain their course of action following the review and the reasons for this.
4. Formalise the arrangements they have put in place to protect patient safety while these investigations continue. This should include the Trust putting in place arrangements to restrict Professor Eljamel's practice such that he is not able to undertake spinal surgery pending the outcome of the GMC's consideration of his ongoing fitness to practise in this area.
5. Ensure that while these restrictions are in place the Neurosurgery department is appropriately resourced and supported. In particular, that consideration is given to providing the department with additional resources to ensure that safe and timely surgical care can continue to be provided.
6. Ensure that Professor Eljamel has access to appropriate personal support as he considers necessary during this time.

Subject to the outcome of the above activity, and in particular any action taken by the GMC to consider his ongoing fitness to practise, it was the review team's view that Professor Eljamel should not be able to return to practising independently in spinal surgery without, as a minimum, a longer term continuation of the supervisory arrangements that are in place in relation to his surgical practice.

The review team were also of the view that these supervisory arrangements should not be lifted until such time as Professor Eljamel's practice had been subject to comprehensive audits of his surgical outcomes and long term data had been collected that provided the Trust's management with sufficient reassurance that his practice was safe and within the national normal parameters for surgical outcomes.

Recommendations for Professor Eljamel

Having read and considered the content of this report the Trust and Professor Eljamel should meet to discuss how the following steps can be taken to improve his wider practice and what support he may need to achieve these:

7. Provide a consultant led service, including seeing patients in clinics, during ward rounds and performing procedures on his patients. He may be supported by a junior colleague but the emphasis should be on him, as the consultant, taking the lead role in providing care to patients. This may help address the issues which were raised in the complaints of Professor Eljamel not being accessible to patients.
8. Familiarise himself with published guidelines on pre-operative marking for neurosurgery. Professor Eljamel should ensure his knowledge of current guidelines is

up to date and the Trust should satisfy itself of this and that he understands the importance of this issue.

9. Ensuring that consent for procedures is planned and managed in such a way that patients are fully informed of risks and benefits and have adequate opportunity to ask questions in a confidential environment. To enable this consideration should be given to taking consent from patients in pre-operative clinic appointments. This may allow more time for Professor Eljamel to appropriately explain the benefits and possible risks associated with surgical procedures and overcome the confidentiality issues he cited. It may also address the issue Professor Eljamel raised concerning staggered admissions on a Sunday and the need for him to be available to take consent prior to surgical procedures on a Monday.
10. Attend MDT and M&M meetings wherever possible and sign the attendance register to document his attendance and aid audit of this. During meetings he should ensure he participates fully in discussions, including presenting his own cases. This is especially important for cases where complications have arisen. A high attendance rate, as well as an open and frank approach to discussing cases with his colleagues would be expected. This would likely be assisted by the Trust making adjustments to the scheduling of clinics, as discussed in the recommendations for the Trust.
11. Provide meaningful teaching opportunities to trainee surgeons during ward rounds and in theatre. These should be appropriate to the level of the trainee and adequately supervised by Professor Eljamel.
12. Be mindful of his interactions with patients and his colleagues, with due regard for how what he says may be perceived by others. To support this it may be beneficial for Professor Eljamel to engage in proactively seeking feedback from colleagues or attending an advanced communication skills course.
13. Ensure that the recruitment of research fellows is conducted appropriately, ensuring that an appropriate job description is in place, that adequate support is sought from other Consultants and there is a rigorous approach to collecting references and matching candidates to the requirements of the position. These steps are essential in making sure that all appointments are adequately qualified to work in the neurosurgery department.
14. Review the amount of time dedicated to study leave and other commitments and the time allowed for clinical practice and other duties at Ninewells hospital. It will be important for Professor Eljamel to ensure that he is able to establish an appropriate balance to allow him sufficient time to care for his patients and avoid an increase in waiting times.

Recommendations for NHS Tayside

The majority of the recommendations that have been made relate specifically to Professor Eljamel's practice as this was the primary focus of the invited review. There were however some issues brought to the attention of the review team, which relate more widely to the

neurosurgical department or the Trust as a whole. NHS Tayside may wish therefore to consider the following recommendations:

15. The current on call arrangements for neurosurgery do not appear to be appropriate as the Consultant scheduled to be in theatre is designated as the on call surgeon. It would be appropriate to adjust this arrangement, perhaps so that a surgeon is on call the evening and the day following their operative list. This would allow continuity of care as any patients developing complications would be seen by the same surgeon who was subsequently on call. It would also eliminate the problem of the on call surgeon being difficult to contact and unavailable to operate in the event of an emergency admission due to them already being in theatre.
16. It would be appropriate for the Trust to ensure that adequate arrangements have been made and that suitable provisions are in place to allow an emergency neurosurgical operation to be conducted while the designated neurosurgery theatre is in use. This would likely involve a second operating theatre being equipped with the necessary equipment to facilitate neurosurgical procedures.
17. To ensure that all of the Consultant Neurosurgeons are available to attend M&M meetings as often as possible it may be necessary for the Trust to revise the current clinic schedule, to ensure that consultants have protected time to attend this important meeting.
18. A review of current clinical governance arrangements may be helpful in ensuring that all those involved are aware of their responsibilities and that a clear and effective mechanism is in place to identify and address possible issues about performance and conduct.

The Trust may wish to remind members of staff of their responsibility to report any concerns they have about the provision of safe and effective patient care and to clarify reporting lines with them.

Responsibilities of the Trust in relation to the recommendations of this report

This report has been prepared by The Royal College of Surgeons of England and The Society of British Neurological Surgeons under the IRM for submission to NHS Tayside. It is an advisory document and it is for the Trust concerned to consider any conclusions and recommendations reached and to determine subsequent action. It is also the responsibility of the Trust to review the content of this report and in the light of these contents take any action to protect patient safety that it considers appropriate.

Further contact from the Royal College of Surgeons following final report

Where recommendations are made that relate to patient safety issues, the Royal College of Surgeons will follow up this report with the Trust to ask them to confirm that the Trust has



addressed these recommendations. The College's Lead Reviewer may be available to support this process.

Where the College is not satisfied that these recommendations have been addressed within a reasonable period of time following the issue of the final report, the College, the Association and/or the Reviewers reserve to themselves the right to disclose in the public interest but still in confidence to a regulatory body such as the General Medical Council, the National Patient Safety Agency or the Care Quality Commission or any other appropriate recipient, the results of any investigation and/or of any advice or recommendation made by the College, the Association and/or the Reviewers to the Hospital.

The College will also contact the Trust to carry out an evaluation of its services following the issue of the final report.

**10. Signature of Reviewers****CAT C**

MR NEIL KITCHEN FRCS

DATE: 06/12/2013

CAT C

MR NICHOLAS PHILLIPS FRCS

DATE: 29/11/2013

CAT C

MS HELEN CARTER

DATE: 03/12/2013



11. Appendices to the Report

11.1 Appendix 1 – Brief biography of the reviewers

Mr Neil Kitchen FRCS, The Royal College of Surgeons of England

Mr Kitchen was appointed as Consultant Neurosurgeon at the National Hospital for Neurology and Neurosurgery in 1995, where he is currently Head of the Division of Neurosurgery for University College London. He is an examiner for the Intercollegiate Examination Board in Neurosurgery, Secretary of the Society of British Neurological Surgeons and a Specialist Advisory Committee member. His clinical sub-specialty interests are skull base and oncology neurosurgery. He also serves on the advisory boards for the 'British Journal of Neurosurgery' and the journal 'Neurosurgery', the latter having the largest circulation and impact factor worldwide. He is a College representative on consultant neurosurgical appointment AACs.

Mr Nicholas Phillips FRCS, The Society of British Neurological Surgeons

Mr Phillips was appointed consultant neurosurgeon at Leeds teaching hospitals in 1997. He is the Training Program Director for neurosurgery in Yorkshire and Humberside, an examiner for the Intercollegiate Examination Board in neurosurgery and lead for pituitary surgery and gamma knife radiosurgery in Leeds. He has specialty interests in Pituitary surgery, surgery for pain including Trigeminal Neuralgia and Radiosurgery. He was clinical director in Neurosurgery for seven years.

Ms Helen Carter

Helen Carter is a freelance consultant working in the health and voluntary sectors. In health, her work has included major service reviews, researching the experience of patients with specific conditions to help develop improved clinical practice and information materials and researching/piloting novel ways of reaching hard to reach groups. A former chair of the European Platform for Patients' Organisations, Science and Industry (EPOSSI), she has been Chief Executive of two health related charities and has served as a non- executive director and Vice Chair on the Board and board adviser to one of the largest PCTs in England. Her professional background is in human relations and organisation development.

11.2 Appendix 2 - Review of patient notes

Case one – description

This case involves excision of a poster fossa lesion and the subsequent development of a pseudomeningocele. This caused symptomatic headaches which were investigated. It was eventually concluded that this was due to the acrylic used in the cranioplasty.

Reviewers' comments

This case had some complicating issues that could have been better communicated with the patient; there was some evidence of failure to take patient concerns seriously.

Case two – description

Wrong level lumbar surgery. Five different junior surgeons saw this patient in the clinic. No x-rays were taken intra-operatively.

Reviewers' comments

Poor supervision of junior staff. Poor operative technique. Poor follow-up arrangements and delay in dealing with on-going symptoms.

Case three – description

An elderly gentleman admitted to the HDU via A&E following a fall in the street on 15 April 2013. The complaint, made by the patient's wife centred around:

1. A lack of communication, the failure of Professor Eljamel to meet with the patient and having to chase up an appointment to see Professor Eljamel.
2. The cancellation (allegedly by a neurosurgeon on clinical grounds) of an oral maxillofacial surgery (OMFS) appointment without being informed prior to the event.

Reviewers' comments

With regards to the first point, the case notes seem, in the main, to support the hospitals' version as set out in their response to the complaint. There remains a potential question about when and how Professor Eljamel first knew that patient wished to meet with him to discuss the case. Without a proper record keeping it is possible that similar misunderstandings about who is supposed to contact whom and when will reoccur. Regarding the second point, although the quality of the notes are generally good in noting the patient and his wife's wish to speak with doctors and their levels of anxiety, the summary sheet is missing key information including about the referral to OMFS.

Case four – description

A case of a progressive lumbar radiculopathy in an elderly patient who could not have an MRI scan because of an implanted pacemaker. The patient waited some time for a myelogram requested by junior doctors.

Reviewers' comments

This patient pathway and experience would have been improved with more senior intervention and leadership.

Case five – description

Wrong site laminectomy performed by a registrar in 2011, "re do" by Professor Eljamel in 2012 with subsequent CSF leak.

Reviewers' comments
Delays in both redoing the laminectomy and in managing the CSF leak. Succession of juniors seeing the patient on the ward and in the clinic. Poor supervision and disjointed care.
Case six – description
Two level cervical disc replacement. Poor outcome, referred on to the pain clinic. Subsequent ulnar nerve and carpal tunnel decompression.
Reviewers' comments
Patient unable to easily meet with Professor Eljamel regarding the failed surgery. Uncertain if the two level disc replacement appropriate.
Case seven – description
Wrong level lumbar surgery. Delay in meeting with patient to discuss surgery and in follow-up.
Reviewers' comments
Patient went to two other neurosurgeons who confirmed that the wrong level had been operated on.
Case eight – description
The patient complained that • A conversation regarding prospective surgery was undertaken in a public area. • This conversation didn't address with the risk and benefits of the surgery. • The patient was misinformed by a junior doctor regarding when she would need to stop taking oral contraception before surgery. • The possible confusion of this patient with another of the same name.
Reviewers' comments
The notes are sparse and the sequence of events is difficult to follow, the notes do not accurately record when oral contraception was stopped. This patient was not seen by Professor Eljamel in the clinic and the issue therefore is with his decision to delegate the management of this patient to a junior colleague.
Case nine – description
A gentleman with deteriorating gait caused by lumbar canal stenosis (complicated by motor neurone disease). The patient, his relatives and general practitioner (GP) all had difficulty getting an appointment and the clinical pathway started.
Reviewers' comments
This case appeared to largely be managed by Registrars, lacking senior supervision, and there was evidence of very poor communication to the patient, relatives and GP.
Case ten – description
The patient was referred by their GP for intermittent paraesthesia, to gain an opinion as to whether imaging of the cervical spine was indicated. The patient was seen in the clinic on 18 November 2010 and referred for an MRI. On 11 January 2011 a letter was sent with the MRI results, the diagnosis of myofascial pain syndrome was misspelled as 'mild facial' pain. The patient complained in June 2011 regarding the misspelling and that they felt 'the consultant was not too interested and was pleased when I told him I had a previous diagnosis of myofascial syndrome elsewhere in my spine'.

Reviewers' comments
Of concern is the fact that the original letter with the misspelling is no longer in the notes and has been replaced by the corrected letter. For the record to be complete, both letters should be in the notes. The letter sent to the patient's GP is fuller and more helpful, and in which Professor Eljamel states he wants to 'leave no stone unturned'. The communication in this case would have been improved if the letter had been sent in full to the patient.
Case eleven – description
After a patient died 'suddenly but not unexpectedly' a complaint was received, alleging poor communication and a delay in the Procurator Fiscal's office being contacted.
Reviewers' comments
There was nothing in the patient's notes to help explain the delay but there appears to have been poor communication within Professor Eljamel's team and a lack of clarity about who was taking responsibility for notifying as appropriate. It appears that the family were made aware at the relevant time that the patient was 'actively dying' and that deep vein thrombosis medication may have contributed to the bleed. They were not however told initially that a dosage higher than usual, but still within acceptable levels, had been prescribed.
Case twelve – description
Bad wound infection post lumbar laminectomy with wound dehiscence.
Reviewers' comments
Delay in treating wound issues post-surgery, lack of input from Professor Eljamel.
Case thirteen – description
Wrong level cervical disc replacement and bad outcome.
Reviewers' comments
Wrong level plus delays in realising this, leading to delay in the case being presented at M&M meeting and rectifying situation.
Case fourteen – description
This is the case of an 89-year-old gentleman presenting acutely with right leg weakness and Brown-Séquard syndrome. An MR scan had shown a prolapsed disc in the thoracic spine at T6/7
Reviewers' comments
The decision to offer surgery at this advanced age shows poor appreciation of risk and benefit and possibly poor assessment of the patient's clinical picture. Wrong level surgery was reported on the MRI scan 6 days after surgery. A written entry in the notes states that failure to improve after surgery was due to haematoma. The second operation that was undertaken illustrates very poor patient focus and raises serious questions of surgical competency in decision-making. This patient died shortly after. There was no evidence apparent of sharing this mistake with either the patient or relatives. Colleagues were misled regarding the first operation.