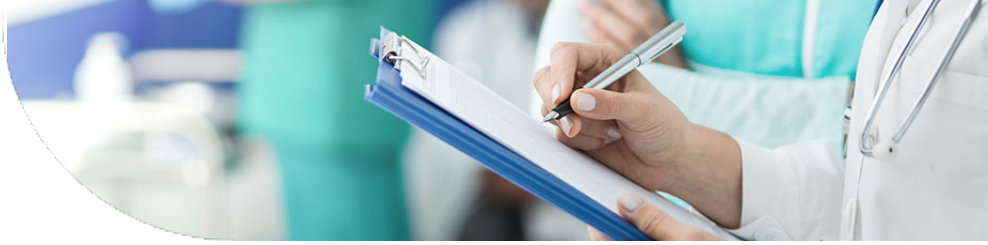

Inquiry Labels the Healthcare System as ‘Dysfunctional at Almost Every Level’

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In 2017, Ian Paterson was convicted of seventeen counts of wounding with intent and three counts of unlawful wounding. He was sentenced to 15 years in jail, which was later extended to 20 years. Despite this conviction, many of his victims, and their families, have been left with unanswered questions about how Paterson’s misconduct managed to escape under the radar for so many years.

As a result, an independent inquiry was set up to investigate these wrongdoings. The findings have now been published and the opening words of the Right Reverend Graham James, the Chair of the Paterson Inquiry, make for uncomfortable reading. He states, *“This report is not simply a story about a rogue surgeon. It would be tragic enough if that was the case, given the thousands of people whom Ian Paterson treated. But it is far worse. It is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were the victims of Paterson’s malpractice were let down time and time again.”*

The inquiry seeks to peel back the many layers of Paterson’s wrongdoings, outlining the key issues at the heart of the inquiry, including how Paterson performed cleavage sparing mastectomies, other types of surgery which he was not qualified to carry out, unnecessary treatment and failure to complete diagnostic tests. The inquiry also reveals how Paterson falsified the coding on his patient’s records, coding their illnesses as cancer when often this was not the case. This later made it difficult for patients to obtain travel insurance, health insurance or a successful job, as many saw a cancer diagnosis as a red flag.

The report is critical not just of Paterson, but of his employers, both NHS and private hospitals, for the failure to investigate concerns raised against Paterson. His colleagues first raised concerns in 2003, but Paterson was only suspended 8 years later, in 2011. The report highlights how a number of colleagues were aware of Paterson’s unusual practices and to some extent, he was “*hiding in plain sight*”. What is still unclear is whether Paterson was actually acting alone. The report states that “*Paterson was not acting in isolation*”, and a number of healthcare professionals have been referred to the GMC and NMC.

The report insinuates that there may have been elements of financial motivation behind the lack of investigation into Paterson’s conduct, particularly in the private sector. Other factors considered by the report include the culture of ‘whistleblowing’ and the historic lack of protection. Despite the fact that healthcare professionals have

a duty to raise concerns where they believe patient safety or care is at risk, in reality it is much more complicated than this. As an example, when four doctors raised concerns about Paterson, they later found themselves subject to a GMC investigation regarding their fitness to practise. Whilst this was not a direct result of their complaints about Paterson, it is likely that other healthcare professionals interpreted this differently, and would be reluctant to raise any concerns, as they may fear the consequences of doing so.

The report also highlights concerns about regulating bodies such as the CQC and GMC, and how patients felt let down by them. In particular, the report sets out there are differences in how CQC regulates, inspects and monitors the NHS and the independent healthcare sector. Interestingly, CQC did not attend the evidence sessions with the Inquiry, which was out of line with the other regulators, who fully engaged. CQC has responded to the Inquiry report, their response can be read here.

Despite a number of recent improvements across the healthcare sector, the report raises concerns that not enough has changed and there is a worry that it is "*entirely possible that something similar could happen now*". The report has made a number of recommendations, including the need for a "*single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data*". The report also recommends, *"CQC, as a matter of urgency, should assure itself that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings"*. The report also suggests, "*the Government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals…and introduce a nationwide safety net to ensure patients are not disadvantaged.*" The full recommendations are set out between pages 218-222 of the report.

Nadine Dorries, Parliamentary Under Secretary of State for Mental Health, Suicide Prevention and Patient Safety, has stated "*it is with deep regret that we acknowledge the failure of the entire healthcare system to protect patients from Ian Paterson's malpractice and to remedy the harms".* She goes on to say *"to conclude, we are absolutely committed to ensuring lessons are learned and acted upon from the findings of this shocking inquiry, in the interests of enhancing patient protection and safety, both in the NHS and the independent sector".*

It is unclear at this stage, whether the Government will implement the recommendations and how long it will take to see any changes.

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