Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 09/01/2017 – 26/01/2017
02/05/2017 – 23/05/2017
18/12/2017 – 16/01/2018
17/04/2018 – 09/05/2018
24/07/2018 – 16/08/2018 and
15/10/2018 – 18/10/2018

Medical Practitioner's name:	Dr Thomas BIESGEN
GMC reference number:	6157121
Primary medical qualification:	State Exam Med 2000 Ruprecht Karl Universität Heidelberg

Type of case	**Outcome on impairment**
New - Deficient professional performance	Impaired

Summary of outcome
Erasure

Immediate order imposed

Tribunal:

Lay Tribunal Member (Chair)	Mrs Michéle Clare
Lay Tribunal Member:	Mr Mick Turner (until 26 January 2017)
Medical Tribunal Member:	Dr Nagarajah Thevamanoharan
Medical Tribunal Member:	Dr Nisreen Booya (from 4 May 2017)

Legal Assessor:	Ms Rosalind Scott Bell (9-10 January 2017 only) Mr David Mason Mr Alastair Forrest (17 and 20 January only)
Tribunal Clerk:	Mr Ian Leslie (9-11 January 2017) Miss Zaheda Razvi (from 12 January 2017 until 18 October 2018)

Attendance and Representation:

Record of Determinations – Medical Practitioners Tribunal

Medical Practitioner:	Present and represented until 10 January 2018 Present and not represented 17 April to 9 May 2018 Not present and not represented on 24 July to 16 August 2018 Not present and not represented on 15-19 October 2018
Medical Practitioner's Representative:	Mr Taher Nawaz present on 9, 16 January in person and attended by telephone on 17 and 26 January. Attended in person on 3 May and by telephone on 4 May – UNTIL 10 January 2018
GMC Representative:	Mr Alan Taylor, Counsel, instructed by GMC Legal

Allegation and Findings of Fact
That being registered under the Medical Act 1983 (as amended):

Patient A

1. Between 27 June 2012 and 10 July 2012, you consulted with Patient A and you failed to:

    a. arrange an appropriate treatment plan, in that you advised an open reduction of Patient A's fracture and fixation with the application of a plate; **Found Proved**

    b. discuss the advantages and disadvantages of the treatment options with Patient A; **Found Not Proved**

    c. discuss the treatment plan with senior colleagues; **Found Not Proved**

    d. make an adequate clinical record, in that you failed to record:

        i. Patient A's occupation;
        ii. Patient A's hand dominance;
        iii. the nature of the injury;
        iv. the date of the injury;
        v. the fact that the fracture had already been manipulated;
        vi. the clinical situation at presentation;
        vii. treatment options;
        viii. the risks of the planned treatment;

ix. the complications of the planned treatment.
Found Not Proved in its entirety

Patient B

2. On 3 July 2012, you consulted with Patient B and you failed to:

    a. arrange an appropriate and/or clinically indicated treatment plan, in that you advised that an external fixator should be applied six weeks following injury; **Found Proved**

    b. refer Patient B for outpatient hand therapy; **Found Proved**

    c. discuss the advantages and disadvantages of the treatment plan with Patient B; **Found Not Proved**

    d. discuss the management of Patient B's injury with senior colleagues. **Found Not Proved**

Patient C

3. On 9 July 2012, you consulted with Patient C and you:

    a. incorrectly diagnosed a fracture of the trapezium; **Found Not Proved**

    b. failed to obtain an adequate medical history, in that an adequate history would have ruled out a fracture; **Found Not Proved**

    c. failed to examine Patient C's hand and/or wrist to:

        i. evaluate swelling; **Found Not Proved**

        ii. elicit the area of maximum tenderness; **Found Not Proved**

    d. failed to record:

        i. an adequate history as to the nature of the injury and the development of Patient C's symptoms; **Found Not Proved**
        ii. an examination of Patient C's hand and/or wrist. **Found Not Proved**

Patient D

4. On 9 July 2012, you consulted with Patient D and you failed to:

    a. arrange an appropriate treatment plan; **Found Not Proved**

    b. arrange an appropriate referral for post-injury hand therapy;

Found Not Proved

c. make an adequate record of:
   i. Patient D's medical history;
   ii. the nature of the injury;
   iii. Patient D's hand dominance;
   iv. Patient D's pre-existing arthritis;
   v. the limited function in Patient D's fingers.
   Found Not Proved in its entirety

5. On 1 August 2012, you consulted with Patient D and you failed to:

   a. adequately assess Patient D, in that you deemed that no further follow up was necessary, but that hand therapy should continue; **Found Proved**

   b. make an adequate clinical record, in that you recorded that Patient D had a full range of movement. **Found Proved**

Patient E

6. On 11 July 2012, you consulted with Patient E and you:

   a. incorrectly diagnosed a fracture of the hamate; **Found Not Proved**

   b. failed to undertake adequate and/or appropriate investigations to make the correct diagnosis. **Found Not Proved**

Patient F

7. On 18 July 2012, you consulted with Patient F and you failed to:

   a. institute an adequate and/or appropriate treatment plan, to include:

      i. adequate and appropriate follow up care; **Found Proved**
      ii. hand therapy. **Found Proved**

   b. make an adequate clinical record, in that you failed to record:

      i. Patient F's age; **Found Not Proved**
      ii. Patient F's social circumstances; **Found Not Proved**
      iii. a history of how the injury was sustained. **Found Not Proved**

Patient G

8. On 18 July 2012, you consulted with Patient G and you failed to:
    a. follow through with the agreed treatment plan of open reduction and internal fixation of the fracture with a plate and screws; **Found Not Proved**

    b. arrange Patient G's admission for surgery, having advised Patient **G** ~~H~~ of the need for surgery; **Found Not Proved**

    c. discuss with Patient G the reasons for changing the treatment plan; **Found Not Proved**

    d. discuss Patient G's treatment plan and changes to it with senior colleagues. **Found Not Proved**

Patient H

9. On 18 July 2012, you consulted with Patient H and you failed to:
    a. follow through with the agreed treatment plan of open reduction and internal fixation of the fracture with a plate and screws; **Found Not Proved**

    b. arrange Patient H's admission for surgery, having advised Patent H of the need for surgery; **Found Not Proved**

    c. discuss with Patient H the reasons for changing the treatment plan; **Found Not Proved**

    d. discuss Patient H's treatment plan and changes to it with senior colleagues. **Found Not Proved**

Patient I

10. On 19 July 2012, you consulted with Patient I and you failed to:
    a. ascertain what the functional problem was for Patient I; **Found Proved**

    b. record what the functional problem was for Patient I; **Found Proved**

    c. arrange an X-Ray of the stiff joint to determine the nature of the underlying problem; **Found Proved**

d. determine an adequate treatment plan; **Found Proved**

e. make an adequate referral to the hand therapist in that:

   i. there was no record made of what you wanted the therapist to do; **Found Not Proved**
   ii. there was no record made of the intended outcome of the proposed treatment; **Found Not Proved**

f. discuss the management of Patient I with senior colleagues. **Found Not Proved**

Patient J

11. On 3 August 2012, you operated on Patient J and you failed to:
    a. undertake adequate and/or appropriate post-operative checks; **Found Proved**
    b. arrange an adequate and/or appropriate treatment plan post-operatively; **Found Proved**

    c. make an adequate and/or appropriate referral for post-operative hand therapy; **Found Proved**

    d. ensure adequate and/or appropriate post-operative monitoring; **Found Not Proved**

    e. keep adequate and/or appropriate notes of the consultation. **Found Not Proved**

Patient K

12. On 3 August 2012, you operated on Patient K and you failed to:
    a. adequately reduce and fix Patient K's fracture; **Found Proved**

    b. arrange an X-Ray to confirm adequate fixation of the fracture; **Found Not Proved**
    c. determine that the fracture was adequately treated; **Found Proved**

    d. discuss the management of Patient K with senior colleagues; **Found Not Proved**

e. record any details of a pre-operative meeting with Patient K.
Found Not Proved

Patient L

13. On 10 October 2012, you operated on Patient L and you failed to record:
    a. details of the circulation in Patient L's thumb at the end of the operative procedure; **Found Proved**

    b. the status of the circulation in the arteries; **Found Proved**

    c. the use or time of a tourniquet. **Found Not Proved**

Patient M

14. On 15 October 2012, you operated on Patient M and you failed to:
    a. identify the injury to the main trunk of the median nerve;
    Found Proved

    b. identify the injury to the palmar cutaneous branch;
    Found Proved

    c. ~~record an operation note~~. **Withdrawn By The GMC**

Patient N

15. On 23 November 2012, you:
    a. were not contactable between 10:00 and 11.40 despite having primary responsibility for patient care; **Found Not Proved**

    b. failed to assess the wound on Patient N's thigh before instructing a junior doctor ('Dr O') to close the wound; **Found Proved**

    c. failed to inform Dr O and/or operating theatre staff:
        i. that you were leaving the operating theatre; **Found Proved**
        ii. of your whereabouts; **Found Proved**
        iii. how you could be contacted. **Found Proved**

Patient P

16. On 23 November 2012, you supervised Dr O who was operating on Patient P, and you:

a. were not familiar with the:
    i. steps required in the surgical procedure; **Found Not Proved**

    ii. surgical equipment needed for the surgical procedure; **Found Not Proved**

b. failed to:
    i. adequately communicate with Dr O who was undertaking the surgical procedure for the first time; **Found Not Proved**

    ii. give adequate and/or appropriate guidance to Dr O **Found Not Proved**

Patient Q

17. On 23 November 2012, despite being rostered to do the Emergency Plastic Surgery list, you:
    a. left the operating theatre whilst Patient Q, who required an urgent procedure, was in the anaesthetic room; **Found Proved**

    b. failed to:
        i. communicate with colleagues to ensure that there was a formal handover; **Found Not Proved**

        ii. inform the operating theatre team of your whereabouts; **Found Proved**

        iii. ensure that there was an adequately experienced and trained surgeon available to complete the list. **Found Not Proved**

And that by reason of the matters set out above your fitness to practise is impaired because of your deficient professional performance. **IMPAIRED**

Attendance of Press / Public
The hearing was all heard in public.

Determination on Adjournment Application - 10/01/2017
Dr Biesgen:

Adjournment Application

1. Mr Nawaz, representing you, made an application to adjourn this hearing until at least April 2017 in order for you to instruct an expert. Mr Nawaz commenced his submission by giving background to the case. He said that the first time you heard

about any complaint was on 17 September 2014, which was a complaint about a "Leeds patient" dating from August 2012. In January 2013, you left Cambridge and went to Zurich to work. In April 2013 hospitals in Leeds and Cambridge were asked by the GMC if there were any further concerns about you, and no clinical concerns were raised by them.

2. Mr Nawaz informed the Tribunal that the incidents in the allegation dated back to 2012, when you were employed by Cambridge Trust at Addenbrooke's Hospital and on secondment in Leeds. However, by October 2014, you faced a number of allegations which were brought before an interim orders panel. Mr Nawaz noted that this case was originally listed from 3 May 2016 until 31 May 2016, in relation to eleven Leeds patients. In January 2016 the GMC asked for an extension of eight weeks to finalise its case and it was given three weeks. On 21 March 2016, in order to investigate further allegations about Cambridge patients, your agreement was sought for a postponement of the May 2016 hearing. In your emails dated 22 March 2016 and 5 April 2016, you agreed to the postponement of the hearing on the proviso that you were given at least six months after the GMC had provided you with a "finite case".

3. Mr Nawaz submitted that the GMC wrote to you on 28 September 2016 providing its draft case and only sent its final case to you on 30 November 2016. He said that this was not a sufficient period of time to enable you to have a fair opportunity to defend yourself. He said there was not an equality of arms, there were massive violations of your human rights and your livelihood was at stake.

4. Mr Nawaz said that the first expert report of the GMC, in relation to patients from the Leeds Hospital, was dated August 2014. The second report on the final Leeds Patient was dated December 2014. Mr Nawaz confirmed that you had received, on 22 July 2016, all of the expert reports regarding the Cambridge patients, barring one supplemental report in relation to one Cambridge Patient. That supplemental report, dated 23 September 2016, was received by you on 28 September 2016. Mr Nawaz stated that you had approached colleagues to prepare an expert report for you, but they were not "independent enough". He said you had spoken to ex-colleagues who may be "independent enough" but they had told you not to do anything until you had the GMC's final reports.

5. Mr Nawaz submitted that, if the GMC needs the amount of time it does with all of its resources to compile its evidence in this case, it is only fair that you should be accorded a reasonable amount of time, with your limited resources, to prepare your response. He noted that the bundle, at 1900 pages, was lengthy. He stated that the five weeks provided to you from the allegations being finalised to this hearing commencing is not sufficient.

6. Mr Nawaz therefore invited the Tribunal to adjourn today's hearing until at least April 2017 to enable a sufficient period to allow you to seek expert evidence in response to the GMC expert.

GMC Response

7. Mr Taylor submitted that you have had since August 2014 to instruct an expert on ten of the 11 patients from the Leeds Hospital. Further information had to be sought in relation to the eleventh and final patient from Leeds. The second expert report on that patient was completed and provided to you in December 2014.

8. Mr Taylor said that, in January 2016, Addenbrooke's hospital had formally referred you in relation to a separate patient. Subsequently, complaints about you were made in relation to four other patients from Cambridge which warranted the postponement of the planned 3 May 2016 MPT hearing.

9. Mr Taylor noted that disclosure of the expert report regarding the Cambridge patients was made to you on 22 July 2016, although the expert wanted further information about one of them. A supplementary report from Mr R dated 23 September 2016 was served on you on 28 September 2016. He said that the notice of allegation, regarding the 11 patients from Leeds and the five patients from Cambridge, was sent to you on 28 November 2016. On 30 November 2016, the paginated bundle was sent to your registered address.

10. Mr Taylor submitted that this case had been listed at a case management hearing on 3 May 2016 when a timetable had been directed. The MPT hearing was listed for 9 January 2017 on the grounds that you would have enough time to prepare. Mr Taylor said that you had had "ample time", the GMC expert finally reporting on all Leeds patients on 15 December 2014 and finally reporting on all Cambridge patients by 28 September 2016. He pointed out that there had been no application to postpone this hearing prior to today.

11. Mr Taylor submitted that there had been no breach of your human rights and no violation of your ability to defend yourself. He said you have been kept informed about the progress of the investigation into the complaints from both Leeds and Cambridge and have had ample time to instruct an expert. He said that any application to adjourn should be refused. It was plainly in the public interest, with allegations going back to 2012, for this hearing to proceed and be concluded expeditiously.

Further Submissions

12. Further written submissions from Mr Nawaz were received by agreement with Mr Taylor, during the Tribunal's deliberation. These submissions were taken into account by the Tribunal.

Legal Advice

13. The Legal Assessor advised the Tribunal that it may adjourn the hearing until such a time and date as it sees fit under Paragraph 29(2) of the GMC Fitness to Practise Rules 2004 (as amended)('the Rules'). The Tribunal should consider the length of any adjournment and the effect it may have on the wider public interest and on you. She advised that you should be given sufficient time to respond to expert evidence; the decision as to whether you have had sufficient time to do so is a matter for the Tribunal.

The Tribunal's Decision

14. The Tribunal noted that you are not legally represented, but that you have been engaged with the GMC proceedings. You have been aware of the date of this hearing since May 2016 and have made no formal application to postpone it prior to the hearing commencing.

15. The Tribunal bore in mind that you have had disclosure of the expert reports on all of the Leeds patients since December 2014. You received the GMC's expert evidence in relation to the Cambridge patients in July 2016, and a supplementary report in relation to one patient in September 2016. The Tribunal observed that the notice of allegation was sent to you on 28 November 2016.

16. The Tribunal considered that, although you may have received information in a piecemeal manner, you knew the charges you were facing, that they were to do with your alleged deficient professional performance, and that expert reports had been provided on behalf of the GMC.

17. You had received a Rule 8 letter in August 2015 and had not organised an expert on your behalf at that stage.

18. Following the Pre-Hearing meeting on 3 May 2016, you were given until 25 November 2016 to disclose any expert report upon which you intended to rely. You made no such disclosure.

19. You have not asked for a postponement and have not provided any evidence of having taken meaningful steps to instruct an expert. Nevertheless, the Case Manager's comments to the minutes of the 3 May 2016 Pre-Hearing meeting clearly advise that, "there may be preparation which Dr Biesgen could now usefully undertake for the matters he knows he will face at a hearing." It appears that you ignored this advice.

20. The Tribunal considered the published MPTS guidance, "Case Management Procedure: guidance for parties and representatives". It particularly noted the

"Agenda for first listing telephone conference" in which there is a section on the "Timetable for preparing of the doctor's case". Its advice makes clear that doctors should prepare their defence case as soon as possible.

21. There is a public interest in hearing your case expeditiously; memories of witnesses fade and the incidents complained of occurred over four years ago. The Tribunal must ensure that each party has the opportunity to present its case fairly. You have been aware of the expert evidence for a significant period of time. You have not even started to find an independent expert despite receiving the final expert report from the GMC over three months ago. You did not seek a postponement prior to the first day of this hearing, when the case was due to start and eight witnesses had been warned. Case management directions were set in May 2016 and it is the view of the Tribunal that you ignored them. You assert that your right to a fair hearing has been breached. The Tribunal is entitled to take into account your behaviour that has led to the circumstances where you find yourself without an expert. The Tribunal has balanced your right to a fair hearing against the overarching objective of the protection of the public and determines that the latter prevails.

22. The Tribunal does not accede to this adjournment application.

Determination on Adjournment and Directions – 26/01/2017

1. Mr Nawaz/Mr Taylor: There is now clearly insufficient time to conclude the case by tomorrow, the last scheduled day. Therefore, the hearing will adjourn part-heard today.

2. Given the stage reached, the fact that there are two GMC witnesses who are yet to complete their evidence, and the way this hearing has been presented, the Tribunal estimates that a further 16 days will be required to conclude the case. It is essential that these directions are complied with and that this case is concluded within the allotted time span. The Tribunal has identified the following dates, which have been agreed in principle:

3. **Tuesday 2 May – Wednesday 24 May 2017**. It is noted that the Tribunal will not be sitting on Friday 5 May as no MPTS hearings will take place that day.

4. It is further noted that Dr Biesgen has indicated that he will not be present on Thursday 11 and Friday 12 May 2017 but that his representative, Mr Nawaz will be present or available by telephone to represent him on those dates.

5. The Tribunal makes the following directions:

1. The defence is to disclose to the GMC details of any witnesses (including Dr Biesgen) upon whom they intend to rely and signed witness statements setting out the substance of their evidence by 5pm on 17 February 2017.
2. The defence is to disclose to the GMC a paginated bundle of any witness statements upon which they rely by 17 February 2017.
3. The defence is to disclose to the GMC any further documents they intend to rely upon by 17 February 2017.
4. The defence is to disclose to the GMC any expert report upon which they intend to rely and a Curriculum Vitae of the expert providing the report by 5pm on 24 March 2017.
5. The GMC is to disclose to the defence a Curriculum Vitae of Mr R, the GMC expert witness by 5pm on 24 March 2017.
6. The GMC is to disclose to the defence any expert report in response by 5pm on 21 April 2017.
7. If both parties intend to rely upon expert evidence, they are to instruct their respective experts either to meet in person or over the telephone to discuss the issues and to produce a joint report to indicate the areas of agreement and disagreement between them by 30 April 2017.
8. Tuesday 2 May is to be a reading day – Wednesday 3 and Thursday 4 May are to complete the evidence of Mr R the GMC expert. On Monday 8 May, Dr S is to be called to complete her evidence. No further time will be allowed in respect of these witnesses without leave of the Tribunal.
9. The defence is to produce paginated versions of D4, D6 and any other documents upon which they rely with translations to English as applicable (7 copies of the bundles are to be provided to the MPTS on the first day of the re-convened hearing).
10. Parties are to confirm in writing to the Case Manager whether they have each complied with the above Tribunal directions by 21 April 2017.
11. If any further directions are required by either party, then an application should be made to the Case Manager.

6. This hearing is now adjourned, to re-convene (In Camera to read) at 9.30 on Tuesday 2 May 2017. It will commence in public session at 9.30 on Wednesday 3 May 2017 to continue with cross-examination of the GMC expert witness.

Determination on Further Directions – 04/05/2017

1. Mr Nawaz/Mr Taylor: The Tribunal adjourned this hearing part-heard on 26 January 2017 and the stage reached was that there were two GMC witnesses yet to complete their evidence. The Tribunal re-convened on Tuesday 2 May 2017 which was scheduled as a reading day in the absence of parties. However, the Tribunal was informed on the morning of 2 May that one of the Tribunal members, Mr Turner, had been taken ill. At the end of 2 May, having heard from Mr Turner who had sought medical advice, it was expected that he would be able to attend on 3 May.

2. On Wednesday 3 May, it transpired that Mr Turner was in fact unable to continue with this hearing and he stood down. Dr Biesgen and his representative were in attendance and were informed together with Mr Taylor of the situation. Efforts were made to secure a stand-in Tribunal member after verbal agreement to this course of action was given by both parties.

3. Today, the Tribunal resumed with its replacement member, Dr Booya. Dr Biesgen is not present today but Mr Nawaz has participated via spiderphone.

Rule 29(5)

4. The Tribunal heard submissions from both parties confirming their agreement to the replacement of Mr Turner by Dr Booya and took advice from the Legal Assessor in relation to Rule 29(5). The Tribunal directs under Rule 29(5)(a) that the hearing will recommence under Rule 17(2)(f), the facts stage, from the point in evidence where the hearing was adjourned on 26 January 2017. No further directions are required on this point.

Witness Scheduling

5. Mr Taylor then addressed the Tribunal with a proposed further timetable for the two remaining GMC witnesses (Ms S and Mr R) to complete their evidence. He stated that Ms S was available on Monday 8 and Tuesday 9 May to complete her evidence. He suggested that Wednesday 10 May be utilised for further case directions relating to another matter. Mr Taylor suggested that the Tribunal then adjourn the hearing and that 6 days (11 to 18 May) be non-sitting days as Mr R, the GMC expert witness, is only available on Friday 19 and Monday 22 May to complete his evidence.

6. On behalf of Dr Biesgen, Mr Nawaz strongly objected to this proposed timetable. His reasons were that his client is a busy surgeon and Head of Department in Geneva, that he has made himself available despite difficulties, and that Mr R should do the same. Mr Nawaz stated that it was unacceptable for the GMC expert to give such limited availability which would have the consequence of delaying this hearing further than necessary.

Tribunal Decision

7. The Tribunal took account of the remaining days in this session of the hearing and concluded that if Mr Taylor's timetable was adopted there was no prospect of completing the facts stage in the time currently available. If Mr R gave evidence on Monday 15 and Tuesday 16 May there would be a good chance of completing the facts stage in the time allotted.

8. The Tribunal is content with the proposed timetable for 8-10 May for the completion of Ms S's evidence and any other outstanding matters.

9. The Tribunal had already noted in its previous directions determination that Dr Biesgen will not be present on Thursday 11 and Friday 12 May 2017 and therefore the Tribunal has accepted that it would be unfair to continue in his absence and will not sit on these two days.

10. The Tribunal makes the following direction in relation to the remainder of the hearing of the GMC's case:

1. The Tribunal will continue with the hearing on Monday 15 May and on that day and the subsequent day it will hear the remaining evidence of Mr R. The Tribunal makes this direction knowing that Mr R may be inconvenienced by it, however, Mr R is a professional witness who has been called to give expert evidence and therefore he has a professional obligation and duty to assist his regulatory body.

11. It is essential that this direction is complied with and that this case is concluded within the allotted time span. The Tribunal has identified further dates, should they be necessary to conclude this case and these will be **Tuesday 24 October – Friday 3 November 2017**.

12. This hearing will continue on Monday 8 May with further cross-examination of Ms S. The Tribunal will now hear evidence from the GMC and Mr Nawaz on their compliance with the directions made on 26 January 2017.

Determination on Application To Amend Directions – 04/05/2017

1. Mr Nawaz/Mr Taylor:

At the conclusion of the last sitting of this hearing, the Tribunal issued a number of case directions which both parties were required to adhere to. Today, the Tribunal has received the email correspondence sent from Mr Nawaz to the MPTS between 26 and 31 January 2017 and the responses to it from both our Tribunal Clerk and from the GMC.

2. The Tribunal received and accepted the advice of the Legal Assessor that it should now consider Mr Nawaz's emails of 26 and 31 January 2017 as an application to vary the Tribunal's directions. Mr Nawaz was particularly concerned about the direction relating to the provision of a witness statement by Dr Biesgen. The Tribunal further comprehensively reviewed the directions made in January as the dates for compliance have now passed.

3. The Tribunal makes the following directions:

1. The defence is to disclose to the GMC a paginated bundle of any witness statements (including any by Dr Biesgen) upon which they rely before any witness is called to give evidence.
2. The defence is to disclose to the GMC any further documents they intend to rely upon by 8 May 2017.
3. The defence is to inform the Tribunal by 8 May 2017 whether or not they intend to rely on the evidence and report of a defence medical expert.
4. The defence is to produce paginated versions of D4, D6 and any other documents upon which they rely with translations to English as applicable by 8 May 2017.

4. This hearing is now adjourned, to re-convene on Monday 8 May 2017 to continue with the cross-examination of Ms S.

Determination on Application To Vary Directions – 10/05/2017

1. Mr Taylor: You have made an application to vary the direction made by the Tribunal on 4 May 2017. That direction was to continue the cross-examination of Mr R, the GMC expert witness, on Monday 15 and Tuesday 16 May 2017. You have provided a letter from Mr R dated 7 May 2017 in which he sets out his professional difficulties in attending the hearing on those dates.

2. In your submission you made a plea on behalf of Mr R that the Tribunal varies the direction so that Mr R does not have to cancel his patients on Monday and Tuesday but you stated that he would be able to re-arrange his outpatient appointments on Wednesday 17 May and Thursday 18 May in order to attend the hearing.

3. By email dated 9 May 2017, Mr Nawaz set out Dr Biesgen's difficulties and made observations about delays in the course of this hearing.

4. Mr Nawaz explained to the Tribunal that Dr Biesgen would have difficulty in attending on Thursday 18 May and therefore proposed that Mr R either continues his evidence on Monday and Tuesday as previously directed, or on Friday 19 and Monday 22 May. Mr Nawaz also indicated that he intends to call Dr Biesgen to give evidence and that could be given in the two remaining days of this session.

Legal Assessor's Advice

5. The Legal Assessor referred the Tribunal to Rules 16(1)(A) and 16(7)(A) of the 2004 Fitness to Practise Rules. He advised that the combined effect of these rules is that the direction made by the Tribunal is binding unless a) there has been a material change in circumstance since the direction was made or b) it is not in the interests of justice for the direction to remain in effect.

Tribunal Decision

6. The Tribunal took account of the submissions of both parties and the advice of the Legal Assessor. It considers that there has been a material change of circumstance in that it is now aware of the extent of the disruption to Mr R's practice and to his patients if he were called to give evidence on 15 and 16 May 2017. In light of this it does not consider that it is now in the interests of justice for the direction to remain in its present form. Taking into account Mr R's letter and Mr Nawaz's submissions on behalf of Dr Biesgen, it now makes the following direction:

1. The Tribunal will continue with the hearing on Wednesday 17 May and on Friday 19 May with continued cross-examination of Mr R. The hearing will continue on Monday 22 to Wednesday 24 May, as scheduled, to complete the GMC case and to hear the evidence of Dr Biesgen. The Tribunal makes it clear that Mr R is to remain available to attend on Monday 22 May, should that be necessary.

7. The hearing is now adjourned until 9.30 on Wednesday 17 May 2017.

Determination on Application To Adduce Documents – 19/05/2017

1. Mr Nawaz: You have made an application to adduce a bundle of documents containing academic articles. You state that these are relevant for cross-examination of the GMC expert and are relevant in relation to each of the patients in the allegation. You also stated that these were emailed to the GMC and the MPTS on 30 April 2017.

2. Mr Taylor, on behalf of the GMC did not submit that the GMC's case was prejudiced but did argue that there is an important principle that directions made by the Tribunal are to be complied with and also that it was not proper for the GMC to be 'ambushed'.

Legal Assessor's Advice

3. The Legal Assessor advised that, as the GMC did not argue prejudice, the Tribunal should consider whether the defence has complied with its direction of service of any documents by 8 May 2017. He also advised that there is a principle that directions of the Tribunal are intended to be complied with and that cases should be presented in an open and transparent manner.

Tribunal Decision

4. The Tribunal noted that you failed to comply with the case manager direction that defence documents must be served on the GMC by 25 November 2016. The Tribunal directions of 26 January 2017 stated that you were required to disclose to the GMC any further documents upon which you intend to rely by 17 February 2017. The bundle of documents you now wish to adduce has been available to you since

January 2017. Only now have you made an application to have it admitted as evidence, albeit the Tribunal acknowledges that some documents, not all of which could be opened, were emailed to the GMC at the end of April 2017. The Tribunal accepts Mr Taylor's submission that there is a principle that its directions should be complied with. As Dr Biesgen is not legally represented, the Tribunal has determined that it would be disproportionate and potentially unfair to the doctor if these documents were not admitted.

Determination on Further Progress Of The Case – 23/05/2017

1. Mr Taylor/Mr Nawaz: Today is the penultimate day for this session of this hearing. Yesterday, the Tribunal finished asking its questions of the GMC expert but you both indicated that you had questions arising from those of the Tribunal. Given the lateness of the hour, there was insufficient time to conclude the expert's evidence yesterday.

2. This morning the Tribunal has been presented with a detailed email sent from Mr Nawaz at 11.52pm yesterday evening.

3. Mr Taylor, you told the Tribunal that you had no submission to make other than that the direction made by the Tribunal on 4 May should stand. You said that when you received Dr Biesgen's statement at the end of the GMC case, you would need time to consider it and refer it to the GMC expert and that it may be necessary to recall witnesses.

4. Mr Nawaz, you submitted that Dr Biesgen should not be required to serve a witness statement on the GMC until after the end of the GMC case. You said that the GMC case had changed in the course of the hearing and that Dr Biesgen wished to hear the whole of the GMC case before completing a witness statement, which is now partly prepared. You said that it was difficult to complete the statement when Dr Biesgen is in another country and cited personal reasons which made it more difficult for him to complete the statement.

Tribunal Decision

5. The Tribunal carefully considered the submissions of both parties. It noted Dr Biesgen's failure to comply with previous directions requiring the service of a witness statement on the GMC. It is concerned that the additional dates for the hearing may be jeopardised if the statement is not served in advance of the re-commenced hearing dates (provisionally set for December 2017 to January 2018).

6. The Tribunal is further concerned that a statement when produced might be more in the nature of a submission than a response to the allegation. A statement is only required to cover Dr Biesgen's response to the allegation against him. It is not intended to take into account the GMC evidence heard during the hearing; the latter

would be more in the nature of a submission on the facts, which will be invited at the end of hearing the evidence on both sides. A submission, made at the proper time, would not be subject to questioning by the GMC. The Tribunal notes that a statement from Dr Biesgen may lead to the recall of the expert witness and possibly of other GMC witnesses. The Tribunal accepts that there are difficulties because of Dr Biesgen's absence from the country and has therefore determined that the present direction made on 4 May 2017 should remain unaltered. Any effect on the proposed resumed dates will have to be dealt with in due course.

7. In view of the uncertainties posed by the question of whether or not Dr Biesgen will apply to submit a statement, the Tribunal has concerns about the length of time required to conclude this case. Given this, the Tribunal has determined that a further 18 days must be allocated. The dates identified and agreed by the Tribunal are as follows: 18- 22 December 2017 and 3-19 January 2018.

8. Unless there are any other matters, Mr Taylor/Mr Nawaz, the Tribunal will now adjourn and resume the hearing on Monday 18 December 2017 to conclude Mr R's evidence.

Determination on 2nd Application To Adjourn Proceedings – 04/01/2018

Dr Biesgen:

Adjournment Application

1. Mr Nawaz, representing you, has made an application to adjourn this hearing due to your unavailability in the next two weeks. He submitted that you had been available from 18-22 December 2017 but that the cross-examination of the expert witness, Mr R had been delayed by his unavailability until 21 December so that the GMC case had not closed. Mr Nawaz in his emails sent to the Tribunal on 2, 3 and 4 January 2018 has stated that you have operations booked which cannot be cancelled and re-arranged, given the short notice. He has indicated that the only day you could attend was on Friday 12 January, but that it was highly unlikely that one day would be sufficient to conclude your evidence. Mr Nawaz also argued at D21 that he was exceptionally busy with professional commitments in January and his availability was therefore limited. The application made by Mr Nawaz on your behalf is for the Tribunal to adjourn proceedings and identify future dates to continue the hearing, with a clearly identified 5 day period for you to attend and give your evidence.

2. Mr Nawaz invited the Tribunal to adjourn today's hearing.

GMC Response

3. Mr Taylor submitted that the GMC opposes the application to adjourn. He submitted that there are two working weeks left of this session and that this time should be used to progress the case. Mr Taylor submitted that you should have made yourself available for the duration of this hearing. He then stated, for the record, that the delays in this case have been caused by your non-engagement pre-hearing and as part of that there has been a wilful failure to comply with any case management directions including disclosure of documents and, most notably, your own witness statement, which was only received on 21 December 2017. He submitted that the delays inevitably had a knock-on effect on witness scheduling and set the pattern for the future conduct of the case. Mr Taylor submitted that the fourth area of delay was caused by the prolonged cross-examination of 2 witnesses, namely Ms S and Mr R.

4. Mr Taylor submitted that adjournments should not to be taken lightly and that an adjournment now may mean a further delay of 6-9 months, which is unacceptable, given that the hearing commenced in January 2017. Mr Taylor referred the Tribunal to the case of Adeogba v GMC [216] EWCA Civ 162 and in particular to the comments contained therein, including, *'any culture of adjournment is to be deprecated'.*

5. Mr Taylor submitted that it is accepted that you have engaged in the hearing process but that you have done so only on your own terms and that you have sought to dictate the Tribunal's timetable. He submitted that the reality is that there are two working weeks left and those should be made use of in order to *'achieve economical, expeditious and efficient disposal of allegations made against medical practitioners',* as set out in Adeogba*.*

6. Mr Taylor submitted that Mr R's further evidence should be concluded next Tuesday and then the GMC can close its case. Thereafter you can re-arrange your commitments in order to attend the hearing to give your evidence. Mr Taylor submitted that no specific detail has been provided about your commitments, other than a generalised account from Mr Nawaz that you have an operating list for the next two weeks, save for Friday 12 January. Mr Taylor submitted that it is ultimately up to you whether you wish to put your work commitments over and above this hearing. He reminded the Tribunal that these dates were listed last May so you have had ample time to rearrange your commitments in order to attend.

7. Mr Taylor submitted that any application to adjourn should be refused as it was plainly in the public interest, with allegations going back to 2012, for this hearing to proceed and be concluded expeditiously.

Legal Advice

8. The Legal Assessor advised the Tribunal that the options available to it were: to refuse the application and to proceed with the case; to adjourn for a short period

within the present listing of the case; or to adjourn to some date in the future beyond the present listing.

9. He advised that a decision to adjourn is a quasi-judicial act, not an administrative decision.

10. The Legal Assessor referred the Tribunal to the case of Jones [2003] 1AC1, Adeogba and Davies v HCPC [2016] EWHC 1593. He advised that the Tribunal should act upon the overarching objective of the GMC, although fairness to the parties, in particular the defence, is important. The Legal Assessor reminded the Tribunal that registrants had a duty to cooperate with their regulator in resolving allegations against them. He said that the discretion to proceed in the absence of a registrant must be exercised with great care and caution.

Additional Submission From Mr Nawaz

11. While the Tribunal was *in camera*, Mr Nawaz sent a further email (D25) in which he rehearsed previously-made arguments and took issue with Mr Taylor's submissions. He raised no issues about the Legal Assessor's advice to the Tribunal. The Tribunal has noted D25 and taken it into account as appropriate. It was offended by Mr Nawaz' repeated allegation of 'complicity of the GMC with the MPTS'. No such complicity exists.

The Tribunal's Decision

12. The Tribunal reviewed the history of the case and noted that there were difficulties timetabling the appearance of witnesses from the start. The Tribunal acknowledged that there has been delay on both sides and GMC witnesses' availability had sometimes been limited and for short periods of the day.

13. The Tribunal considers that a doctor against whom allegations have been made is in a different position to GMC witnesses and noted that, in the case of Davies, the court said that a registrant had a duty to cooperate with a regulator in relation to the *'investigation and resolution of allegations against them.'*

14. The Tribunal has noted that Mr R is available to be recalled on Tuesday 9 January at 4pm and, if necessary, on Thursday 11 January. The Tribunal wishes to make best use of the time available and will therefore sit in public session from 16:00hrs GMT on Tuesday 9 January with the intention of concluding Mr R's evidence. Mr Nawaz anticipates that this should take no longer than one hour. You have already shown that you are competent to cross-examine witnesses on clinical matters. The Tribunal will have no objection to you undertaking the cross-examination of Mr R by telephone. There is also no objection to a short break following your cross-examination for you to confer with Mr Nawaz and for you or he to ask further questions of Mr R, if you wish.

15. The Tribunal then expects the GMC case to close and that the defence will open its case.

16. The Tribunal has taken full account of the interests of both parties. However, it has placed particular emphasis as required by the overarching objective on the public interest in disposing of this case expeditiously and efficiently.

17. Accordingly, the Tribunal rejects your application to adjourn proceedings. It will continue with the hearing on Tuesday 9 January 2018 (Friday 5 and Monday 8 January will be non-sitting days).

Determination on Suitable Representation – 10/01/2018
Dr Biesgen:

1. The Tribunal has considered whether Mr Nawaz is a suitable person to continue to represent you in this hearing.

2. At the outset of this hearing, the Tribunal permitted Mr Nawaz to represent you applying Rule 33(1)(c) of the Fitness To Practise Rules. This was on the basis that although Mr Nawaz is an accountant and not a lawyer, he had said that he had wide experience of judicial proceedings.

3. The Tribunal has now reconsidered whether Mr Nawaz is a suitable person to represent you. The Chair has repeatedly warned Mr Nawaz that because of his conduct the Tribunal might reconsider his suitability and also whether his conduct amounted to disruption of the proceedings. The Tribunal is concerned that Mr Nawaz has been repeatedly rude and insulting to the Tribunal, to GMC Counsel and to the Legal Assessor. Mr Nawaz also repeatedly failed to comply with directions given by the Case Manager and the Tribunal as to the disclosure of documents and the provision of your witness statement.

4. The Tribunal considers that Mr Nawaz fails to understand the process and lacks an understanding of the need to comply with directions. It notes with concern that Mr Nawaz advised you that you would complete giving your evidence in December 2017. However, there was no basis for giving such advice, not least because the GMC had not closed its case and Mr Nawaz insisted that he would not serve your witness statement until it had done so. There was therefore no realistic prospect of you completing your evidence in December 2017. On the basis of Mr Nawaz's advice you arranged various clinics and operations during this sitting in January. You therefore have not attended this sitting and you have said that the only date you can attend is Friday 12 January 2018.

5. In a determination dated 4 January 2018, the Tribunal ruled that it would sit at 4pm GMT on Tuesday 9 January 2018 so that you could cross-examine the GMC expert on clinical issues. In the event you were on a train in Germany, and despite attempts by the Tribunal with which you co-operated, it was impossible because of technical problems for you to cross-examine the expert. The Tribunal is particularly concerned that Mr Nawaz had failed to notice that the dates you provided for your clinical activities in January indicated that you were in fact available on 9 January and therefore could have properly engaged in the hearing. It was Mr Nawaz's responsibility as your representative to ensure that you were available in some suitable location to take part in the hearing and to cross-examine the expert witness.

6. The Tribunal has tolerated Mr Nawaz's discourtesy throughout this protracted hearing because he was your chosen representative. Despite repeated warnings it is clear to the Tribunal that Mr Nawaz has no understanding of how to conduct himself as an advocate. The Tribunal notes that, despite being invited by it to produce evidence of his experience, he has failed to do so. The Tribunal believes that it was misled by the claims Mr Nawaz made as to his experience and competence as an advocate. The Tribunal considers that Mr Nawaz has hampered the proper conduct of this case. His conduct is disruptive and unhelpful to the Tribunal and to you. The Tribunal is concerned that Mr Nawaz's cross-examination of witnesses has been unfocused, rambling and irrelevant, wasting Tribunal time.

7. The Tribunal accepts that you chose Mr Nawaz as a representative in good faith. However, his conduct of the proceedings has not been to your advantage. It has noted that, when you questioned witnesses, you did so competently and were willing to take advice as to the suitability of questions. The Tribunal is satisfied that your conduct in these proceedings has been courteous, professional and appropriate. It has been most careful to ensure that Mr Nawaz's conduct does not reflect upon its view of you or this case.

8. The Tribunal having found Mr Nawaz to be not a suitable person to represent you leaves you without representation. It is now open to you to represent yourself or to seek alternative representation. It notes that you are able to attend on Friday 12 January 2018 and strongly encourages you to do so in order to determine the future progress of your case.

9. This determination will be emailed to you and to Mr Nawaz. The Tribunal would be greatly assisted if you would communicate your intentions to the Tribunal Clerk by 9.30am GMT Thursday 11 January 2018. The Tribunal will sit on Thursday 11 January and will consider your response. It will consider any applications you wish to make at that time. The Tribunal will not consider any communication from Mr Nawaz, verbal or written.

10. Pursuant to Rule 33(1)(c), the Tribunal finds that Mr Nawaz is an unsuitable person to represent you and withdraws its consent for him to do so.

Determination on Proceeding Further With The Hearing – 11/01/2018

Dr Biesgen:

1. On Wednesday 10 January 2018, the Tribunal determined that Mr Nawaz was an unsuitable person to represent you and withdrew its consent for him to do so. That determination was sent by email to you at 12.17pm and you were asked to take particular note of the following: *'The Tribunal would be greatly assisted if you would communicate your intentions to the Tribunal Clerk by 9.30am GMT Thursday 11 January 2018. The Tribunal will sit on Thursday 11 January and will consider your response. It will consider any applications you wish to make at that time.'*

2. The Tribunal re-convened this morning but as the Tribunal Clerk had not received a response from you, she was asked to telephone you in order to ascertain whether you had received the determination and whether you intended to participate in the proceedings. You then forwarded the emails that you had sent to the GMC/MPTS (but not to the Tribunal Clerk as had been requested in the determination). The Tribunal resumed in public session at 10.10am and the Chairman relayed the conversation that you had with the Tribunal Clerk. At this point Mr Taylor made clear that the emails sent from you had in fact been sent yesterday to the GMC and MPTS. Therefore, when the telephone call was made, there was confusion because the Tribunal did not know of your two emails of 10 January.

3. In the telephone call this morning you said that you may be able to participate tomorrow afternoon by video-link during gaps between your clinics. An email was then received from you at 10.21am in which you stated that the Tribunal expected you to attend tomorrow (12 January). The Tribunal wishes to make clear that it was not the intention for you to attend in person tomorrow to continue with the hearing but only that you participate by video-link in order to speak to the Tribunal about the continuation of your hearing.

4. The Tribunal considers that there is still some misapprehension on your part about the purpose of tomorrow's hearing. It is of the view that because you are now unrepresented, you will be helped by receiving guidance from the Legal Assessor as to procedure and your options from now on. The Tribunal then expects you to clarify your position having received guidance from the Legal Assessor. The Tribunal would emphasise that this is the purpose of the video-call tomorrow and there is no intention to require you to give evidence tomorrow.

5. The Tribunal having heard from you and having clarified your position will then consider your application to adjourn. It accepts that on the basis of the advice you were given by Mr Nawaz you have arranged clinics and operating lists for the whole

of next week and therefore it is inevitable that you cannot attend next week. The Tribunal will take all of this into account when considering the application to adjourn.

6. To allow a video-link to be arranged please provide your video-conferencing details and times when you are available to the Tribunal Clerk by 9.30am GMT on Friday 12 January 2018.

Determination on the 3rd Application To Adjourn Proceedings – 15 January 2018

Dr Biesgen:

1. The Tribunal has carefully considered your email response to the determination that was sent to you on 11 January 2018 on proceeding further with your case. In your email, which was sent on 11 January 2018 at 23:40 GMT, you state: *'…For some reason the panel seems to be ignoring the fact that six out of the first eight weeks have been lost entirely as a result of mismanagement of time management at the hearings whilst GMC witnesses have made themselves unavailable as they chose. The panel needs to consider this: I am in full time employment and cannot possibly take endless periods of time off work. One has to be realistic. Is there serious expectation on the part of the panel that I am expected to turn up on an unlimited basis regardless of whether the proceedings reach any conclusions? For this I'm afraid neither I nor Mr Nawaz can be blamed but the GMC and the mismanagement of listings with GMC witnesses taking time out whenever they felt like it. …
if there is no adjournment to these proceedings to allow me to arrange proper representation and my giving evidence, my involvement in these proceedings must be regarded as being at an end.'*

2. The Tribunal has regarded your email as a renewed application to adjourn these proceedings.

GMC Response To The 3rd Adjournment Application

3. Mr Taylor submitted that this third application to adjourn proceedings should be refused and that the hearing should continue in order to utilise the remaining time available to the Tribunal in this sitting.

4. Mr Taylor relied on the submissions he made in relation to the 2nd application to adjourn proceedings, the determination of which was handed down on 4 January 2018.

GMC request To Revisit The Previous Determination

5. Mr Taylor invited the Tribunal to revisit its determination on 'Suitable Representation' which was handed down on 10 January 2018. He submitted that the email of 11 January 2018 (D30) changes everything, in that the determination on

suitable representation proceeded on the basis that Mr Nawaz was solely responsible for the predicament that you found yourself in. However you make clear in your email that*, 'It was not Mr Nawaz who advised me to not provide for any time after 20 December. The fact is that I have some common sense and can work out that if the proceedings had been properly managed we would have been able to conclude the evidence part of the proceedings before 22 December.'* Given your comments, Mr Taylor submitted that the Tribunal should now revisit its determination and in particular paragraphs 4, 5 and 7.

6. Mr Taylor submitted that the tone of your email shows contempt for the regulatory process and that you are fully compliant with and complicit in what has happened to date. He submitted that the Tribunal has been gracious and generous towards you and given you an opportunity to communicate your intentions and that you have, "t*hrown it back in its face".* Mr Taylor submitted that the Tribunal has done its utmost to assist you but this has been met with contempt. He further added that you are seeking to dictate the direction of the Tribunal and expect it to accommodate your work commitments. Mr Taylor concluded that fairness also includes to the regulator and that it was your prerogative if you wish to withdraw from proceedings.

Legal Advice

7. The Legal Assessor advised the Tribunal that in the circumstances of this case, consideration of whether to accede to the application to adjourn the case is in effect a consideration of whether to proceed in your absence. He advised the Tribunal to proceed with great care and caution in making this decision. The Legal Assessor advised that the starting point for deciding the issues are the principles set out in the criminal case of Jones [2003] 1AC1. The Tribunal was required to consider whether you would be voluntarily absenting yourself if you chose not to attend the adjourned hearing and whether a fair hearing would be possible in your absence.

8. The Legal Assessor further advised that the Tribunal should consider the cases of Adeogba v GMC [2016] EWCA 1 62 and Davies v HCPC [2016] EWHC 1593. The relevant principles to be applied in this case are that the Tribunal must be guided by the overarching objective of the regulator: *'the protection, promotion and maintenance of the health and safety of the public'* and the duty upon registrants *'to engage with the regulator in relation to the investigation and resolution of allegations against them.'*

The Tribunal's Decision

9. The Tribunal accepts that in light of D30, it appears that you have been complicit in Mr Nawaz's behaviour and conduct of these proceedings.

10. The Tribunal has comprehensively reviewed the history of this case. It has noted your comments that *'If the hearing had been adjourned on 9 January* [2017] *we would not have had the disaster that we have had, of three separate listings,*

because the GMC witnesses were not available for six out of the eight weeks' of listings.' Although the responsibility of GMC witnesses to appear is different from that of a doctor under investigation, the Tribunal accepts that the availability of GMC witnesses has caused major timetabling issues for this hearing and resulted in wasted time.

11. The Tribunal has taken full consideration of the history of the case and records that you and your former representative, Mr Nawaz have also contributed to the delay. In particular it finds that the cross-examination of witnesses by Mr Nawaz was unfocused and to a considerable extent irrelevant, which inevitably caused further delay.

12. In reviewing the history of the case, the Tribunal considers that you have not complied with your duty to co-operate with your regulator. In particular it notes the following:

- that you have failed to comply with any direction made by the Case Manager or the Tribunal;
- that you accepted clinical responsibilities in January 2018, on dates that conflict with those for which this case had been listed since May 2017;
- that on 4 January 2018, although you were aware that the Tribunal was convening to give you an opportunity to further cross-examine the GMC expert, Mr R, you chose to be on a train at the relevant time, which effectively made you unavailable;
- it was intended that you would attend by video-link or telephone to consider the further conduct of the case on Friday 12 January. However, by your email of 11 January you made it clear that you would not take part in that consideration.

13. In considering your third application to adjourn, the Tribunal takes fully into account that because of its decision to withdraw consent for Mr Nawaz to represent you, you are now without representation. You have indicated that you wish to seek representation. The Tribunal also takes fully into account that you are unable to attend the hearing during this week because of the clinical commitments which you have arranged.

14. The Tribunal has taken account of the interests of both parties. It has placed particular emphasis as required by the overarching objective on the public interest in disposing of this case expeditiously and efficiently. Taking into account the principles to be applied as advised by the Legal Assessor, your lack of representation and your inability to attend the hearing this week, the Tribunal accepts that this hearing cannot conclude this week.

15. Accordingly, the Tribunal accedes to your application to adjourn proceedings.

The Tribunal will re-convene to continue this hearing on the following provisional dates:

Tuesday 17 April to Wednesday 9 May 2018 (15 days)

16. Please note that that the Tribunal will not be sitting on Friday 27 April and also on Monday 7 May (which is a bank holiday).

17. The Tribunal makes it absolutely clear that it expects you to attend on these dates, with or without representation, and that the hearing will conclude by 10 May 2018.

Determination on Timetabling For Reconvened Dates – 16 January 2018
Dr Biesgen:

1. The Tribunal has carefully considered your email response to the determination that was sent to you on 15 January 2018 on adjourning the hearing. In your email (D31), which was sent to the Tribunal Clerk on 16 January 2018 at 08:27 GMT, you state:

> *'I note that you wish to have my confirmation that the dates proposed are suitable. I try to attend on 17 April and for the remaining week. I want to be sure this time that I am not left hanging around because of other people's problems and wish to have an assurance that there will be some attempt at proper time management and, on the basis that any issues relating to Mr R can be dealt on the morning of 17 April and my evidence can be dealt with in the next couple of days thereafter, with written submissions to follow, so that I should not be expected to attend for three further weeks. I would find it impossible to take three further weeks off, bearing in mind the enormous amount of time that has already had to be taken off.*
>
> *Is it possible for some sort of time tabling to come through so that we can get ourselves organised? I hope that we can have clear time-tabling and look forward to receiving same so that if a witness is not available we are not left hanging around. For instance, Mr R could be dealt with on the morning of 17 April and, on the basis of the calculations made on 21 December, hopefully two days would be enough for my evidence. Could we have clarification for the rest of the procedure with regard to closing submissions so that we can be clear that Mr Taylor can provide his submissions either orally or in writing and I can then be given the chance to respond, where I would hope to respond in writing? Is there any way that a timescale can be worked out in advance of the hearing?'*

GMC Response
2. Mr Taylor submitted that for the record he does not accept your comments regarding GMC witnesses and does not accept that they have caused any of the

delay. He submitted that you are expecting a timetable to be set in order to arrange your availability, which he said was not possible. Mr Taylor also commented about Mr R's availability and his own and said that he could not, at this stage, give any assurances as to availability.

Legal Advice

3. The Legal Assessor observed that Mr R has three months to reorganise his commitments, which should be sufficient. He also commented that, if the Tribunal requires Mr R to be present on 17 April, it is expected that he will be in attendance either in person or by telephone.

The Tribunal's Decision

4. As stated in the determination announced on 15 January 2018, the Tribunal will re-convene to continue this hearing on the following confirmed dates:

Tuesday 17 April to Wednesday 9 May 2018 (15 days)

5. The Tribunal will not sit on Friday 27 April and Monday 7 May 2018.

6. The Tribunal can only set out the (potential) stages of the resumed hearing and cannot give any guarantee as to timings. However, in order to assist you and meet the request you have made in your email the Tribunal makes the following directions:

TRIBUNAL DIRECTIONS

- That the defence submit any additional documentary evidence or witness statements they propose to rely upon to the GMC and to the Tribunal Clerk by 19 March 2018.

- Mr R must make himself available on 17 and 18 April 2018, in order to complete his evidence. On the first day of the resumed hearing (Tuesday 17 April 2018) the Tribunal will expect Mr R to be in attendance at 9.30am either in person or by telephone, for you or your representative to cross-examine him on his supplementary report. Cross-examination must be limited to those matters covered by the supplementary report. Following the conclusion of Mr R's evidence, the GMC will close its case.

- You will then be invited to open your case and to give evidence if you wish. You may also call any further evidence to support your case. The timing of your evidence will depend to some extent on whether you are represented. The Tribunal reminds you that potentially your evidence will consist of examination in chief, cross-examination by GMC Counsel, re-examination, Tribunal questions and further examination arising from Tribunal questions. You should not assume your evidence will only take 2 days to complete.

- When you close your case, the GMC will make its submissions on the facts. You will then be given an appropriate period to prepare your submissions. You will then make your submissions on the facts. It is expected that both of these submissions together will take approximately a day. The Legal Assessor will give his advice and the Tribunal will then go *in camera* to deliberate and to draft its reasons on the facts; this is likely to take 7 to 8 working days. Your presence will not be required during the *in camera* time.

- You will be expected to attend to receive the determination on the facts. If any culpable facts are found proved, the hearing will move to the second stage, for which your attendance will be required. If a finding of impairment is made, the Tribunal will move to the third stage to consider what, if any, sanction to impose on your registration. You have the right to give or call further evidence at any stage of the proceedings.

- If you appoint a representative who is not legally qualified, he/she must produce evidence of his/her experience and expertise in regulatory hearings in the UK. This will allow the Tribunal to assess his/her suitability.

7. The Tribunal makes it absolutely clear that it expects you to attend on the specified dates, with or without representation, and that the hearing will conclude on or before 9 May 2018. The Tribunal will now adjourn until 17 April 2018.

Determination: 4th Application To Adjourn Proceedings - 20/04/2018
Dr Biesgen:

1. The Tribunal has carefully considered your application to adjourn proceedings until 2.30pm on Monday 23 April 2018. You informed the Tribunal that you had arranged appointments to see patients next week and therefore had limited availability to continue with your evidence (which would be via a telephone link). You stated that you could continue your evidence from around 2.30 to 3pm on Monday and similarly on Tuesday. It was not clear how much availability you might have on Wednesday and Thursday. Friday is a pre-agreed non-sitting day.

GMC Response
2. Mr Taylor submitted on behalf of the GMC that he strongly opposed your application to adjourn proceedings once again due to your lack of availability.

3. Mr Taylor reminded the Tribunal of paragraph 7 of the determination handed down on 16 January 2018 which stated, *'The Tribunal makes it absolutely clear that it expects you to attend on the specified dates, with or without representation, and that the hearing will conclude on or before 9 May 2018. …'* The dates specified in the determination were 17 April to 9 May 2018.

4. Mr Taylor submitted that you are expecting a timetable to be set in order to suit your availability, which he said was not acceptable and that there is a real danger of this hearing going part-heard again.

Legal Advice

5. The Legal Assessor advised the Tribunal that a decision to adjourn is not merely an administrative function as it affects the rights of parties. He advised the Tribunal that it was analgous to a decision to proceed in absence and that the Tribunal should proceed with great care and caution. He referred the Tribunal to the cases of Adeogba v GMC [2016] EWCA 1 62 and Davies v HCPC [2016] EWHC 1593, which emphasised the importance of the public interest, the requirement of a doctor to cooperate with his regulator and the need to prevent proceedings being frustrated by the non-attendance of a doctor.

The Tribunal's Decision

6. Having given such clear direction in January 2018 regarding your attendance, the Tribunal is disappointed that it is yet again considering another application to adjourn proceedings.

7. The Tribunal is very concerned that you appear to be seeking to dictate its timetable, which would increase the likelihood of these proceedings again being adjourned part-heard. The Tribunal notes that you are prepared to continue with your evidence on the telephone for part of Monday and Tuesday next week. However, the Tribunal's sitting hours are 9.30am to 5pm and that is the period for which you are expected to be available. You have been aware of this since the start of these proceedings. It is not in the public interest to adjourn the case again, particularly since the Tribunal has no guarantee that you would be available for all the hearing days and for the specified hours after such an adjournment. The Tribunal therefore rejects your application to adjourn.

8. The timetabling of this hearing is for the Tribunal to set. At 9.30am on Monday 23 April 2018, assuming you are not present, the Tribunal will hear GMC submissions and then determine whether to proceed with this hearing in your absence.

Determination: Application To Proceed In Dr's Absence - 23/04/2018

Mr Taylor:

1. On Friday, following the announcement of the Tribunal's determination to reject Dr Biesgen's fourth application to adjourn proceedings, an email was sent to him informing him of this decision. This morning it has received an email from Dr Biesgen sent at 08:13 in which he makes 13 points, as follows:

'1. When the subject of my evidence has being discussed, Mr Taylor started that he may need one day for his cross examination.
2. I promissed 3,5 days this week again.
3. ON Tuesday no more of 2 hours of evidence was possible.
4.On wednesday 18.04.2018 no more than 1 hour of evidence took place,but I allowed Mr Taylor to have a full day on Thursday, because I stopped my witness statment.
5. Mr Taylor has had 1,5 days of cross examination on Thursday and half Friday.
6. We have getting a repeat, what we have had this hearing since January last year.
7. I really maked it clear, that I make myself available 3,5 days and also last friday.
8. It seemed, that I am been blamed for this poor time management.
This is not fair.
9. I work full time and I am head of department with also activities in two countries.I cannot afford to take large chunks of time off.
Bearing in mind that the evidence part of this hearing should be finished in January 2017.
How can you expect me to take time off and loose my job?
10. I understand that the MPTS needs the hearing room on friday. It is maybe possible for me to shift my operations from thursday to friday.
So I can be available on phone this Thursday.
11. I can also be available Monday and Tuesday afternoon (from 14 PM german, also 13 PM UK time).
12. I hope, that this will be more than enough, because Mr Taylor mentioned that one day was all that he needed.
13. I note, that similar orders where made for the may hearing yet he was able to rang around the hearing. I cannot see , why the generally order should not be changed as there where for Mr R in may.'

GMC Response

2. You submitted on behalf of the GMC that the above points made by Dr Biesgen in his email are the same as those he made in person last Friday. You strongly opposed Dr Biesgen's suggestion to proceed with the hearing only when he is available this week, namely today from 2.30pm, Tuesday for 2hours and possibly on Thursday if he can re-arrange his commitments.

3. You submitted that the hearing should proceed in Dr Biesgen's absence as there is a very real danger of the hearing not being able to conclude in the allocated time and will, as a consequence, have to go part-heard again.

4. You once again reminded the Tribunal of paragraph 7 of the determination handed down on 16 January 2018 which stated, *'The Tribunal makes it absolutely clear that it expects you to attend on the specified dates, with or without*

representation, and that the hearing will conclude on or before 9 May 2018. …' You submitted that Dr Biesgen has chosen to ignore this clear direction.

5. You concluded your submission by stating that *"enough is enough"* and that significant progress can be made if the hearing was to continue in Dr Biesgen's absence.

Legal Advice

6. The Legal Assessor referred the Tribunal to the relevant principles contained in the case of R v Jones [2002] UKHL 5 as follows:

> *'The judge must have regard to all the circumstances of the case including, in particular:*
> *(i) the nature and circumstances of the defendant's behaviour in absenting himself from the trial or disrupting it, as the case may be and, in particular, whether his behaviour was deliberate, voluntary and such as plainly waived his right to appear;*
>
> *(ii) whether an adjournment might result in the defendant being caught or attending voluntarily and/or not disrupting the proceedings;*
>
> *(iii) the likely length of such an adjournment;*
>
> *(iv) …;*
>
> *(v) …;*
>
> *(vi) the extent of the disadvantage to the defendant in not being able to give his account of events, having regard to the nature of the evidence against him;*
>
> *(vii) …;*
>
> *(viii) …;*
>
> *(ix) the general public interest and the particular interest of victims and witnesses that a trial should take place within a reasonable time of the events to which it relates;*
>
> *(x) …;*
>
> *(xi) ….'*

7. He advised the Tribunal that the decision to proceed in absence should be treated with great care and caution.

8. The Legal Assessor also referred the Tribunal to the cases of Adeogba v GMC [2016] EWCA 1 62 and Davies v HCPC [2016] EWHC 1593, and informed it that the facts were rather different to the present case as, in those cases, the registrants failed to attend the hearing or to communicate with their regulator.

9. The Legal Assessor referred the Tribunal to the principles set out in paragraph 19 of the case of Davies, as follows: *'First, the principles which apply to proceedings in the absence of a defendant in a criminal trial are a useful starting point. However, it should be borne in mind that there are important differences between a criminal trial and fitness to practise proceedings. The decision of a panel must be guided by the main statutory objective of the regulator; the protection, promotion and maintenance of health and safety of the public. Second, fair economical, expeditious and efficient disposal of allegations made against a registrant is of very real importance. Third, fairness includes fairness to the practitioner and also fairness to the regulator. Importantly, unlike a criminal court, a panel does not have the power to compel the attendance of the registrant. Fourth, the regulator represents the public interest. Accordingly it would run entirely counter to the protection, promotion and maintenance of the health and safety of the public if a practitioner could effectively frustrate the process and challenge a refusal to adjourn when that practitioner had deliberately failed to engage in the process. Fifth, there is a burden on registrants to engage with the regulator in relation to the investigation and resolution of allegations against them. Sixth, in many regulatory cases the rules make it mandatory for a registrant to provide a current registered address. Failure to comply with this mandatory obligation may give rise to disciplinary sanctions. In such circumstances it is for the registrant to ensure that notices sent by the regulator to that address come to his attention.'*

10. The Legal Assessor advised the Tribunal that in this case the granting of an adjournment would secure the attendance of Dr Biesgen, but not to the full extent of the time for which the Tribunal would normally sit.

The Tribunal's Decision

11. In considering whether to proceed in the absence of Dr Biesgen, the Tribunal bore in mind that it has the discretion to proceed with the case in his absence. It also took into account that this discretion should be exercised with great care and caution; and with the overall fairness of the proceedings in mind. The Tribunal also bore in mind the need to balance Dr Biesgen's interests with the public interest.

12. The Tribunal considers that Dr Biesgen is not deliberately refusing to attend the hearing but is dictating the times when he can make himself available. The GMC state that by doing this he is frustrating the hearing process. The Tribunal understands that this amounts to frustrating the process but is of the view that Dr Biesgen is trying to co-operate. The Tribunal notes that Dr Biesgen was present on 17, 18, 19 and the morning of 20 April. He has told the Tribunal that he has many clinical commitments. Dr Biesgen is clearly a very busy man and is trying his best to

continue participation in the hearing, even if it is for very limited periods and not every day. The Tribunal considers that the Public interest is protected as he is not practising in the UK.

13. Accordingly, the Tribunal rejects your application to proceed in Dr Biesgen's absence. The Hearing will continue at approximately 1pm when Dr Biesgen will be available on the telephone to continue with his evidence.

Determination: Adjournment and Directions - 03/05/2018

1. Dr Biesgen/Mr Taylor: There is now clearly insufficient time to conclude the case by Tuesday 9 May 2018, the last scheduled day. Therefore, the hearing will adjourn part-heard again today.

2. The Tribunal has heard Dr Biesgen's oral evidence and, as he is not calling any further evidence, the next stage is to hear submissions in closing on the facts from both parties. The Tribunal estimates that a further 17 days will be required to conclude the case. It is essential that this direction is complied with and that this case is concluded within the allotted time span. The Tribunal has identified the following dates, which have been agreed in principle:

3. **Tuesday 24 July – Thursday 16 August 2018**. It is noted that the Tribunal will not be sitting on Friday 3 August 2018.

4. The Tribunal makes the following directions:

- The GMC and Dr Biesgen shall deliver to the MPTS written final submissions not later than 4pm on 17 July 2018. If a submission is not received by that time, submissions will not be accepted from that party. The submissions are to be sent to the following 3 addresses:

  XXX
  XXX
  XXX

- Transcripts will be provided and will be available via the Secure File Transfer System (SFTS). They cannot be sent by email. Dr Biesgen is therefore required to contact the MPTS IS department in order to access these transcripts.

5. This hearing is now adjourned, to re-convene at 9.30 on Tuesday 24 July 2018. It will commence in public session to hear submissions in closing on the facts.

Determination on Facts - 13/08/2018
Mr Taylor/Dr Biesgen
1. Since the start of this hearing on 9 January 2017, the Tribunal has determined and handed down 15 separate determinations on a range of applications. In addition two applications were made at the outset of these proceedings on day 1 and 2 for which only verbal notification of the decision was given. The reasons for those decisions have been incorporated in this determination as follows:

Application for Representation – Day 1 – 9 January 2017
Dr Biesgen applied for Mr Nawaz to represent him as he was familiar with the case and had helped Dr Biesgen to build the defence bundle.

Mr Nawaz stated that, even though he was not a lawyer, he had been in a court as an expert witness on several occasions.

Mr Taylor stated that whether Mr Nawaz was a fit and proper person to represent Dr Biesgen was a matter for the Tribunal's discretion.

Following the GMC Fit and Proper Persons guidance, the Tribunal was satisfied that Mr Nawaz was suitable for the role and had no reason to doubt that he was honest or credible.

The Tribunal therefore acceded to Dr Biesgen's request to be represented by Mr Nawaz.

It later transpired that Mr Nawaz would not be available for every day of the hearing and on certain days Dr Biesgen would be unrepresented.

Application under Rule 34(13) – Day 2 – 10 January 2017
Mr Taylor made an application for the following to give evidence to the Tribunal by video link, under Rule 34(13):

- Mr T, who was juggling childcare and work commitments;
- Mr U who had an operating list that could not be covered;
- Ms V who had childcare commitments;
- Mr W who had an operating list that could not be covered; and
- Ms X, who was unlikely to be able to give live witness evidence owing to the timing of this hearing.

Mr Taylor stated that they were based in Cambridge which was approximately an eight hour round trip. He said it was in the interests of justice to hear from these witnesses and that Dr Biesgen would be able to cross examine them.

Dr Biesgen raised concerns about the evidence of Messrs T, W and U being heard via videolink as they would need to see colour photographs that they did not have access to. He also said that, even if it was sent electronically, the pictures would be pixelated and hard to decipher.

Dr Biesgen further raised concerns about all five of the witnesses who Mr Taylor requested via videolink as the Tribunal would not see the reactions and demeanour of the witnesses.

The Legal Assessor advised the Tribunal to consider each witness separately as it may come to a different conclusion on each of them.

The Tribunal bore in mind the practical issues raised and considered that there would be no unfairness in allowing each witness to be heard by video link. Regarding Messrs T, W and U, the Tribunal determined that permission was granted subject to the entire bundle being available to the witnesses with identical quality exhibits to those that were available to the Tribunal.

The Tribunal determined that all five witnesses could be heard via videolink subject to the condition above in the case of Messrs T, W and U. If the conditions could not be met, the witnesses would have to attend in person.

The Tribunal added that, as long as the video evidence was of decent quality, it was content to continue.

Background to the Case

2. Dr Biesgen graduated in the State Exam Med from the Ruprecht Karl Universität Heidelberg, Germany, in 2000. He completed a doctoral thesis (Dr med/PhD) in June 2003 and was subsequently awarded the following:

- Specialist in Plastic, Reconstructive and Hand Surgery in October 2007;
- Specialist in Foot and Ankle surgery in January 2011; and
- Specialist in Hand Surgery in 2013.

3. Dr Biesgen worked in various hospitals internationally. He told the Tribunal that he was made a consultant in January 2009 and from 2015 he has been the Head of the Department of Plastic Surgery at a Teaching Hospital in Switzerland.

4. On 10 August 2012 Ms S, Consultant Plastic Surgeon, Leeds Teaching Hospital NHS Trust (Leeds) sent a letter expressing concerns about Dr Biesgen's clinical practice to her Clinical Lead, and this was subsequently sent to the GMC. Dr Biesgen was employed as a microsurgical fellow at Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust (Cambridge) and had been seconded as a Locum Consultant in Plastic Surgery at Leeds to cover maternity leave. Leeds reported concerns about the standard of care provided by Dr Biesgen to eleven

patients. The Deputy Medical Director of The Leeds Teaching Hospitals NHS Trust wrote in his letter to the GMC dated 26 February 2013: *'During his time at Leeds Teaching Hospitals concerns were expressed by his consultant colleagues about his clinical skills, in particular one patient complaint which is the subject of litigation for the Trust.'* Ms S not only intervened in cases where she considered that Dr Biesgen had mismanaged her own patients but also acted upon concerns that others had expressed to her about his competence and clinical skills.

5. As part of the investigation into the Leeds allegations, the GMC wrote to Cambridge, to notify them of the referral, and to enquire whether any adverse incidents had been recorded in relation to Dr Biesgen during his time at Cambridge. Cambridge reported a number of instances where the staff had made complaints about him. As part of the investigation into the Cambridge complaints, the GMC was informed of clinical incidents in relation to five patients, which raised cause for concern. The Executive Medical Director of Cambridge University Hospitals NHS Foundation Trust wrote in his letter to the GMC dated 12 July 2013: '*In summary, the concerns relating to Dr Biesgen included: His documentation was below an acceptable standard for a senior trainee or consultant. His communication with seniors and recognition of potential problems was unreliable. It was felt that he has a paucity of self-awareness: he seems to have a convincing CV, and seems initially very believable and competent.'*

6. The concerns, which arose over a relatively short period of time (July/August 2012 in Leeds; and October/November 2012 in Cambridge), were similar in nature. The GMC alleges they were such that Dr Biesgen had to be restricted to an observer/supervised role in Hand Surgery in Leeds. He was also withdrawn from the on-call rota as well as from outpatient local anaesthetic and trauma lists in Cambridge.

7. A GMC Expert Report dated 18 August 2014 on the Leeds patients was compiled by Mr R, Consultant Plastic Surgeon. Mr R also provided an expert report dated 18 July 2016 on the Cambridge patients. In addition, Mr R produced a further supplementary report dated 2 January 2018 during the course of these proceedings.

Witnesses and Evidence

8. The Tribunal received written statements from the following witnesses:

- Ms S, Consultant Plastic Surgeon, Leeds
- Mr T, Consultant Plastic Surgeon, Cambridge
- Ms O, Honorary Plastic Surgical Registrar, Cambridge
- Mr U, Consultant Plastic and Hand Surgeon, Cambridge
- Patient M
- Ms Y, Senior Medical Staffing Advisor, Cambridge
- Mr W, Consultant Plastic Surgeon, Cambridge

9. Mr W, Ms O, Patient M, Mr U, Mr T and Ms S also provided oral evidence to the Tribunal. In relation to their evidence the Tribunal makes the following observations:

- Mr W (Day 3) – the Tribunal found Mr W to be a credible witness in the sense that he was neutral and reported what he could actually recall. He was sincere and honest and the Tribunal had no reason to disbelieve his account of events.
- Ms O (Day 4) – the Tribunal considered that Ms O seemed to dislike Dr Biesgen's approach to supervision as she felt she required more support than he gave her. Additionally, the Tribunal thought she had exaggerated the problem in Patient P, a procedure which was completed successfully, an outcome that the Tribunal considered would not have been achieved if Ms O's account was completely accurate. In evidence, she admitted that there were different teaching styles, and the Tribunal concluded that Dr Biesgen's simply did not suit her. She was not dishonest, but clearly did not warm to Dr Biesgen's supervisory style.
- Patient M – dental nurse (Day 5) – the Tribunal noted that Patient M had worked at the A&E department and therefore knew how the system worked. It is clear that Dr Biesgen did not make a good impression on her. The Tribunal found her to be sincere and honest in her account.
- Mr U (Day 4) had limited involvement but appeared to be honest and sincere in his approach.
- Mr T (Day 4) – the Tribunal found him to be a credible witness who was professional in his manner. His evidence was measured and entirely credible.
- Ms S (Days, 8, 9, 15 and 16) – the Tribunal found Ms S to be sincere and credible as a witness. At times she displayed arrogance in her comments regarding Dr Biesgen. She showed some curtness during Mr Nawaz's cross-examination; however, this was in the face of rambling, rude and aggressive questions on his part.

Documentary Evidence

10. The Tribunal observes that some of the allegations are based entirely on the notes and therefore it is worth noting that there were issues with the quality of some of the paperwork. In particular, some of the x-rays were undated, not timed and not accompanied by a report. This hampered the GMC expert and the Tribunal. The patient notes were also not always in chronological order and, at times, the Tribunal could not be sure that pages were not missing. For example, the operation note for Patient M was produced during this hearing.

Expert Evidence

11. In addition to receiving the two expert reports from Mr R the GMC expert witness, the Tribunal also received a supplementary expert report during the course of the proceedings. The Tribunal considered that where he had been provided with poorly reproduced photocopies of x-rays, he should have requested the originals. Mr

R also criticised Dr Biesgen for failing to arrange referrals for hand therapy, for example with Patient B and Patient D. It would have been helpful to the Tribunal had Mr R also requested physiotherapy records in relation to several of the patients. It noted that because he had not requested original documents, the Tribunal could not rely on a number of his conclusions.

12. The Tribunal heard oral evidence from Mr R on 10 days during the course of this protracted hearing (days 6, 8, 10, 18, 20, 21, 23, 25, 34 and 35). The Tribunal found him to be a good witness who maintained his professionalism and good humour in the face of hostile cross-examination and insulting accusations. The evidence that he gave was sincere. However, by his own admission he had not been in active hand surgery practice since 2007. Prior to 2007, he had been a specialist in hand surgery for many years. Whilst he was unfamiliar with some of the specific equipment that Dr Biesgen had mentioned, for example, a Smith and Nephew external fixator, he knew what external fixators were for and how to use them. The Tribunal was told that the procedures covered in the allegation were all straightforward and Mr R was confident that he had the expertise to be able to comment upon them.

13. The Tribunal noted, in relation to Patient J, that Mr R appeared to change his evidence on day 20. A close reading of the transcript on that day shows an extremely long, somewhat confused cross-examination. Mr Nawaz misled the witness by substituting the word 'undertake' with 'instigate'. Despite the Chair's correction, Mr Nawaz continued to say 'instigate' as well as the word in the allegation, 'undertake'. Mr R stated: *'…because the charge is 'Failure to instigate', I would state that actually I would alter my opinion on that point and say that he clearly did instigate it because he has noted it in his operation note.'* that the meaning was different. He therefore agreed to change his opinion. In the more ordered re-examination and during subsequent questioning, Mr R reverted to his original opinion. The Tribunal did not consider this affected Mr R's credibility.

Dr Biesgen's Evidence

14. Dr Biesgen chose to give oral evidence both in person and via the spiderphone from Switzerland. This evidence was given in a protracted manner and over a number of days due to his work commitments (days 35, 36, 37, 38, 39, 41, 43 and 44). The Tribunal found Dr Biesgen to be a confident witness, despite the linguistic limitations evidenced in his written and verbal communication. His other limitation was his lack of understanding of the medical system in hospitals in the UK in comparison with that in Europe. These two areas hampered him.

15. However, the Tribunal also found Dr Biesgen at times to be over-defensive and arrogant. He appeared to be full of his own self-importance and took every opportunity to tell the GMC witnesses how successful and renowned he was as a surgeon. He also denied having been limited in his roles at Leeds and Cambridge despite documentary evidence of this. He was vague about the dates he was present

at Leeds. He was evasive at times and would launch into a lecture instead of answering questions posed to him. He made the statement that he was his own expert. The Tribunal could not accept this as an expert must be independent and must act in support of the Tribunal. Clearly as the doctor before the Tribunal he could not act as his own expert; however, he persisted in asserting this and also derided Mr R as being a "non-expert".

16. There were undoubtedly communication problems at both Leeds and Cambridge. The Tribunal concluded that Dr Biesgen was to an extent left to sink or swim at Leeds as Ms S told it that it was up to a locum to find out how the system worked. For a foreign doctor that would have been a greater challenge than for a British doctor.

17. The Tribunal has taken careful account of D20, Dr Biesgen's written witness statement and of D38, his written submissions on the facts.

18. In D20 Dr Biesgen set his qualifications, education and work experience. He provided a commentary on his role at Addenbrooke's Hospital, Cambridge and the Leeds Teaching Hospitals Trust. Dr Biesgen also addresses the issues raised in these GMC proceedings and the complaints made in relation to Patients A to Q.

19. The Tribunal noted that in Dr Biesgen's 59 page submission, 25 pages consisted inter alia of criticisms of alleged 'failings of the GMC', 'failings of the MPTS', allegations of partiality and incompetence of the Tribunal Chair, and criticism of the Legal Assessor.

20. In terms of the GMC, there is no doubt that the investigation of Dr Biesgen's case was prolonged. This Tribunal has already commented on the quality of the paperwork and the photocopies of the x-rays. There is no doubt that the GMC bundle was in places difficult to follow, with pages not being in chronological order and there appear to be pages missing.

21. As to the alleged failings of the MPTS, among many criticisms Dr Biesgen alleged collusion between the GMC and the MPTS. The Tribunal has seen no evidence to support that assertion. Moreover, the Tribunal is clear that its role is independent of the GMC. D38 also suggests that, because one Tribunal member had made an observation favourable to the doctor, he was in some way punished by being assessed. This allegation is roundly rejected; observations of Tribunal members are routine.

22. As to Dr Biesgen's criticisms of the Chair, the Tribunal is confident that she has worked hard to ensure a fair hearing in the face of obstructive and unprofessional behaviour from Dr Biesgen's representative (Mr Nawaz). She endeavoured to ensure that both parties were able to present their cases fairly in the face of substantial timetabling problems. Because of his application to adjourn on

the first day of the hearing, the timetable for hearing the GMC witnesses was disrupted and some of these key consultant level witnesses were unable to be present at short notice, so time was inevitably lost. Dr Biesgen and his representative also had difficulties in attending and therefore flexibility was afforded to them too and they were allowed to participate by telephone.

23. The Legal Assessor made every effort to ensure that Dr Biesgen was aware of the process and also suffered several unprovoked attacks on his competence in open hearing.

24. At the start of Dr Biesgen's oral evidence he stated that he had great experience of plastic and hand surgery in his 18 year career and that since 2009 he had been in a permanent consultant position; the last 5 years as Head of Department. Dr Biesgen asserted that he had never had any case made against him and that he has been doing expert reports for the past seven years in hand trauma cases. Dr Biesgen stated that this was in contrast to the GMC expert witness, Mr R who had not worked in the field since 2007 and who only did four hand procedures a year whereas he undertook 10 or more in a busy day. He stated that this highlighted the difference in his and Mr R's experiences and that is why he could not regard him as an expert in the field. Dr Biesgen told the Tribunal that he did not need to instruct an expert witness as he regarded himself as an expert. As to the allegations made, Dr Biesgen stated that he was never told of any complaints and was completely unaware of the concerns raised in this hearing. He added that his contract at Cambridge was renewed for another six months and this would not have been the case had there been any real concerns about his performance.

25. Dr Biesgen confirmed that he stood by the comments he made about each of the cases in his written statement. The Tribunal has taken into account all of the points Dr Biesgen has made in relation to each of the paragraphs of the allegation and will refer to them as appropriate.

Legal Assessor's Advice

26. The Legal Assessor advised that the burden of proving its case is upon the GMC and that the required standard of proof is the civil standard, the balance of probabilities. He further advised that the Tribunal should consider each paragraph of the allegation individually and take particular note of the wording so that it could ascertain what it was the GMC had to prove.

27. The Legal Assessor advised that he word 'failed' in this context means culpably failed. The GMC must show there is a duty to do something and that the doctor had not complied with that duty.

28. In relation to witnesses, the Legal Assessor advised that the Tribunal could accept or reject the evidence of a witness in whole or in part. He further advised that there would have to be cogent reasons to reject the evidence of an expert

witness. The Legal Assessor advised that Dr Biesgen could not be an expert in his own case. An expert is independent of the parties and owes a duty to the Tribunal, not to an individual party.

29. Finally the Legal Assessor advised that the Tribunal would need to consider the lengthy written submissions of the parties with great care. In relation to Dr Biesgen's submissions, the Legal Assessor advised that the Tribunal should consider his criticisms and decide if there had been unfairness or bias.

The Tribunal's Approach

30. In reaching its decision the Tribunal considered all the evidence adduced, oral and documentary, as well as the detailed written submissions made by Dr Biesgen and by Mr Taylor on behalf of the GMC. The Tribunal has made reference to them under the relevant paragraphs of the allegation in this determination.

The Tribunal's Decision

Patient A

31. The GMC Expert witness, Mr R, provides a summary of the case of Patient A. In his report he states that Patient A sustained an injury to his little finger playing football on 27 June 2012. He initially attended a minor injuries unit and was advised to attend the A&E department of Leeds General Infirmary (LGI). At LGI he was seen by a nurse who confirmed a fracture of the base of the proximal phalanx with a degree of ulna deviation. A doctor manipulated the finger under local anaesthetic block, applied a splint and took x-rays. It was noted that after manipulation the position of the broken bones was better. A hand clinic appointment was made for 4 July 2012. Patient A was seen by Dr Biesgen and listed for an open reduction and internal fixation of the fracture the following day under local anaesthetic. Ms S saw Patient A subsequently and noted he had bilateral clinodactyly (medial angulation of the little fingers, a congenital condition). She noted no rotational deformity of the finger compared with the uninjured side and advised conservative management.

Patient A

18. Between 27 June 2012 and 10 July 2012, you consulted with Patient A and you failed to:

e. arrange an appropriate treatment plan, in that you advised an open reduction of Patient A's fracture and fixation with the application of a plate; Found Proved

32. Mr R's opinion is that Dr Biesgen advice for an open reduction of the fracture and fixation with the application of a plate was inappropriate, if as described by Ms S, the fracture was stable and there was no significant angulation or rotational deformity. He stated that to undertake a surgical fixation of the fracture would be unnecessary and would result in further scar formation and increased stiffness.

33. In his witness statement Dr Biesgen says: *'This is the case of an active 23-year-old patient who had injured himself playing football and I felt that it was necessary to repair the damage so that a further injury did not result in yet more damage. The patient had suffered the injury on 27 June 2012 and I saw the patient on 4 July 2012 so that there was no great risk for the procedure being suggested within a week of the injury. It appears that [Miss S] took the decision on 6/7/12 (C2/P73) that the patient suffered from Clinodactyly. Although there are x-rays (C5/pp1-3) these are undated, of only one hand, and it can be seen that there was a fracture with the finger in bad shape and requiring correction but with no x-ray of the other hand to suggest or prove that the patient was affected by Clinodactyly. There is a danger in such cases of potential compression injuries, if not taken care of, that the patient may suffer arthritis in later life. … the point is clear that this patient needed treatment which was denied to him by [Miss S] who stopped the operation without any discussion with me.'*

34. The Tribunal first considered whether Dr Biesgen had a duty to arrange an appropriate treatment plan. It accepted the expert evidence, that as the treating locum consultant, Dr Biesgen had a duty not only to devise a plan but to ensure that it was appropriate. At C2 page 72, Dr Biesgen wrote a treatment plan. The expert's criticism (at C2 page 70 point 4.14) is that the fracture only required a splint to allow healing and to give pain relief. Ms S stated that when she saw the patient on 6 July she cancelled the operation on the grounds that there was no rotational deformity, the fracture was stable and that the patient had bilateral clinodocatyly. She placed the fingers in a volar splint and said she would look at the patient again on 11 July. The expert maintained his opinion that Dr Biesgen's treatment plan was inappropriate. He stated `*Clinodactyly… is diagnosed clinically and does not require an X-ray of the other hand to make the diagnosis…In my opinion this patient had a stable fracture that was not significantly displaced and therefore did not require open reduction and internal fixation.'* He went on to state *'my opinion is that it was not necessary to do it, but of course there is no problem with doing that, but it was not necessary to do that to make the diagnosis that the patient actually had bent little fingers and they were bent before the injury and they were bent afterwards. That is not an indication of intervening and fixing the fracture.'*

35. The Tribunal reviewed the patient notes carefully and observed that the nurse on 27 June had commented that there was ulna deviation of the left little finger. Following a ring block and manipulation, the nurse had commented that there was slight improvement and the patient was referred to plastic / hand clinic. Dr Biesgen saw the patient on 5 July and recorded that the fracture angle was approximately 30 degrees and there was a cruciate from the fifth to the fourth finger. He therefore decided to carry out an open reduction and fixation with the application of a small T plate. On 6 July Ms S saw the patient and noted that there was no rotational deformity. The fracture was stable and the patient had bilateral clinodocatyly. The operation was therefore cancelled. On 1 August she confirmed that there was no rotational deformity. The Tribunal accepts the weight of evidence produced by the

nurse and Ms S and the opinion of the expert witness that the procedure proposed by Dr Biesgen was inappropriate.

36. Accordingly, paragraph 1a is found proved.

f. discuss the advantages and disadvantages of the treatment options with Patient A; Found Not Proved

37. Mr R's opinion is that it would have been necessary for Dr Biegsen to have discussed with Patient A the advantages and disadvantages of the options for conservative and operative management of the fracture. Dr Biesgen should then have advised Patient A what he considered the most appropriate treatment and how that treatment plan would be undertaken in terms of the surgery and the post-operative care.

38. In his witness statement Dr Biesgen states: *'my notes appear to be missing and it is likely that a second page of notes has been excluded from the bundle. Certainly, the typed notes on C2/p74 indicate that "The patient has been informed about the operation" which is effectively a discussion about the operation itself and with attendant advantages and disadvantages of the process. A possibility that the patient was informed about a potential date for the operation is unlikely as no date appears to have been fixed.'*

39. The Tribunal has taken account of the letter to the GP at page 74 of the bundle and the diagram at page 72 showing where Dr Biesgen proposed to place the T-plate. Dr Biesgen made no record of discussing the advantages and disadvantages of the treatment option. However, the Tribunal has inferred from the fact that Dr Biesgen drew a diagram of his planned procedure that he had discussed his planned procedure with the patient. Additionally, Dr Biesgen's witness statement states that he did discuss the operation's advantages and disadvantages. The Tribunal, on the balance of probabilities found that Dr Biesgen did discuss the advantages and disadvantages of the treatment options.

40. Accordingly, paragraph 1b is found not proved.

g. **discuss the treatment plan with senior colleagues**; Found Not Proved

41. Mr R stated that there is no evidence of any communication between Dr Biesgen and senior colleagues relating to the treatment of Patient A. He said that given that the treatment of the proposed injury was complex and that Dr Biesgen had been asked to discuss case management with his colleagues, his failure to discuss the management of the case was inadequate.

42. Dr Biesgen denied emphatically that he was required to discuss cases with senior colleagues. Ms S's record made in August 2012 (C2 part 2 page 3) states that Dr Biesgen had not been discussing patients with colleagues as advised by Mr Z. The Tribunal has not heard from Mr Z or been given any evidence as to what Dr Biesgen may have discussed with him. Ms S's evidence in this respect is hearsay and the Tribunal has therefore given it less weight than Dr Biesgen's denial.

43. Accordingly, paragraph 1c is found not proved.

h. make an adequate clinical record, in that you failed to record:

x. **Patient A's occupation**; Found Not Proved

xi. **Patient A's hand dominance**; Found Not Proved

xii. **the nature of the injury**; Found Not Proved

xiii. **the date of the injury;** Found Not Proved

xiv. **the fact that the fracture had already been manipulated**; Found Not Proved

xv. **the clinical situation at presentation**; Found Not Proved

xvi. **treatment options;** Found Not Proved

xvii. **the risks of the planned treatment**; Found Not Proved

xviii. **the complications of the planned treatment** Found Not Proved

44. Mr R stated that the contemporaneous note of the consultation does not record details of Patient A's; occupation, hand dominance, the nature or date of the injury, that the fracture had already been manipulated, the clinical situation at presentation fracture stability, angulation or rotation. It does not record treatment options and risks and complications of the planned treatment. He therefore considered the recorded information to be inadequate.

45. In his witness statement, Dr Biesgen stated: *'I have to reiterate that I believe there were further notes of mine which appear not to have been included and that if the file already has data it seems pointless to have to repeat it at every stage. If all surgeons were to do so I suspect a lot less operations would take place than those that are taking place at present.'*

46. In his oral evidence Dr Biesgen denied that the clinical record is wholly inadequate. He stated that the information is already there in the patient's clinical notes and therefore there was no need for him to repeat it all.

47. The Tribunal considers that, as all the relevant information set out at paragraph 1di-ix is already contained in the patient's notes, there was no obligation on Dr Biesgen to repeat these. Indeed the Tribunal noted that other consultants in the unit did not always document such detail in their notes and therefore including such detail could be seen more as a gold standard than as necessity.

48. The Tribunal has noted that the RGN on 27 June (page 65-67) recorded the patient's occupation, hand dominance, the nature of the injury and the fact that the fracture had already been manipulated. The date of the injury is recorded in the A&E entry at page 57. At page 74 Dr Biesgen has recorded the clinical presentation. He has recorded his preferred treatment and the Tribunal considers it more than likely that there is a page missing because at the top of page 72 is written *'left little finger,'* which is clearly a continuation from another page. Furthermore the page that is contained in the bundle (page 72) has no date or time. The Tribunal concluded that a missing page may have mentioned treatment options although there is no evidence that the risks and complications of the planned treatment were on such a page. Additionally, the consent form is certainly missing and this would have included information about the risks and complications of the procedure. Accordingly, paragraph 1di to ix is found not proved.

<u>Patient B</u>

49. The GMC Expert witness, Mr R, provides a summary of the case of Patient B. Patient B presented to the Wharfedale Primary Care Centre /Minor Injuries Unit (PCC/MIU) on 24 June 2012 saying that 4 weeks earlier on 26 May he had sustained an injury to his left ring finger. He had been playing cricket and been struck by the ball on the end of the finger causing an axial compression of the digit. His finger was swollen at the proximal interphalangeal joint (PIPJ) and there was still residual swelling and difficulty flexing the joint. An x-ray confirmed a fracture of the base of the middle phalanx. A referral was made for review in the hand clinic at LGI. Patient B was seen by Dr Biesgen in the hand clinic on 3 July 2012. The fracture was confirmed and it was also noted that, although full extension was possible with some pain, flexion at the PIPJ was limited to 70°. Patient B was advised to undergo an operation to apply an external fixator to the digit. Dr Biesgen advised Patient B about the difficulty of fixing the fracture. No surgery was undertaken and Patient B was next reviewed in the hand clinic at the beginning of August (date redacted). Ms S advised Patient B that surgery was not appropriate at this stage as it was now 10 weeks following the injury. In Mr R's opinion, surgery was not indicated when Patient B was seen by Dr Biesgen 5 weeks after the injury. A plan was made for out-patient hand therapy and Patient B was reviewed on 19 September 2012. It was noted that the range of mobility had improved, although there was minor tenderness over the joint. Further out-patient therapy was advised followed by review in 2 months.

Patient B

19. On 3 July 2012, you consulted with Patient B and you failed to:

e. **arrange an appropriate and/or clinically indicated treatment plan, in that you advised that an external fixator should be applied six weeks following injury;** Found Proved

50. Mr R was of the opinion that the advice to apply an external fixator some 6 weeks following injury was inappropriate. He stated: *'I do not consider that the treatment plan proposed by Dr Biesgen was appropriate or clinically indicated. Fixation of a finger fracture 6 weeks post injury is inappropriate as the fracture will already have healed. Immobilisatlon in a fixator would produce more stiffness in the joint and would therefore not be clinically indicated.'*

51. In his written statement, Dr Biesgen stated: *'Firstly, the patient had not gone to hospital following his injury but only did so when the pain persisted. It is clear that an issue existed and needed to be addressed; Secondly, the x-ray clearly showed an improperly fixed fracture which would cause the patient pain and suffering for the rest of his life as there was a compression fracture which would have rapidly become arthritic and it was necessary to fix the problem for what was a 40-year-old patient; and thirdly, cutting open and fixing an incorrectly joined fracture into a correct position is not unique but common practice in cases of poorly joined fractures.'*

52. In cross-examination, Ms S was asked whether she would intervene to remove two or three loose bits of bone. She responded:

'No.
Q You would leave them there.
A This patient presented four weeks late, so four weeks after his original injury and he actually then was seen by Mr Biesgen five and a half weeks post injury and he was told at that point that he would need an external fixator applied to the joint.
Q A Smith and Nephew fixator.
A At five and a half weeks after injury, you would not apply an external fixator to a fracture because you have already missed the opportunity to do that. You do not see radiological union of a fracture until many months post clinical union, so the x ray appearances are irrelevant in this case, and there is something about radiological union and clinical union; there is a difference here… all you can do is start physiotherapy. Actually, this patient had a reasonable range of movement and I had to spend a lot of time explaining to him why we would not intervene and how we were going to proceed.
Q … There are bits of bone and you would do nothing about it.

A Not at five and a half weeks post injury because clinical union has already happened. If you put an S fix on that joint, he will never move the joint again. That is what would have happened, so this patient would have come to harm.'

53. In his oral evidence Dr Biesgen stated that he would not be concerned about limiting movement by placing the fixator and stated that he considered it to be a *"very good treatment to help fix the bone and to move the joint".*

54. The Tribunal has already agreed that there was a duty on Dr Biesgen to arrange an appropriate treatment. Dr Biesgen thought he saw the patient 4 weeks after injury, but it was in fact five and a half weeks after; he was therefore wrong about the dates. The expert and Ms S agreed that it was inappropriate to apply an external fixator so long after injury. The injury happened on 26 May, the patient did not report to A&E until 24 June and was seen by Dr Biesgen on 3 July. By that stage the fracture would have started to mend and therefore application of an external fixator, which carried additional risks of causing stiffness in the joints, was inappropriate. The Tribunal has noted Dr Biesgen's evidence that in Germany a more interventionist approach would be taken; however, the Tribunal accepted the views of the expert and Ms S that surgery was inappropriate in this case.

55. Accordingly, paragraph 2a is found proved.

f. **refer Patient B for outpatient hand therapy;** Found Proved

56. Mr R was of the opinion that: *'Dr Biesgen should have referred Patient B for out-patient hand therapy, which he failed to do. I consider this to be inadequate and inappropriate treatment.'*

57. In his witness statement, Dr Biesgen stated: *'As the primary treatment was an operation, referral to hand therapy was not appropriate.'*

58. The Tribunal has found that Dr Biesgen made the wrong decision (to operate); thus he inevitably made the wrong decision not to refer the patient for hand therapy.

59. Accordingly, paragraph 2b is found proved.

g. **discuss the advantages and disadvantages of the treatment plan with Patient B;** Found Not Proved

60. Mr R was of the opinion that *'there is no evidence in the information available to me that the advantages and disadvantages of the treatment options were discussed with Patient B. Discussion of the treatment options and the pros and cons of those options would be considered to be a necessary part of the pre-operative*

consultation process. A failure to do this would be considered inadequate and inappropriate.'

61. In his witness statement, Dr Biesgen stated this *'is incorrect. C2/79 clearly indicates that "I have informed the patient about the difficult sedation [sic] of the fracture with not so many possibilities to deal with this problem especially when this operation would" have risks. I had explained to the patient that without the operation he could lose full range of movement and that with the operation, as will all operations, there was risk.'*

62. The Tribunal has noted the document at page 79 which details Dr Biesgen's treatment plan (the surgical procedure) and some evidence that he probably discussed the advantages and disadvantages of that plan. Notwithstanding the fact that it was the wrong treatment plan, Dr Biesgen did discuss its pros and cons.

63. Accordingly, paragraph 2c is found not proved.

h. discuss the management of Patient B's injury with senior colleagues. Found Not Proved

64. Mr R was of the opinion that: *'there is no evidence available to me of any discussion between Dr Biesgen and his colleagues relating to the treatment of Patient B. Given that the treatment of the injury was complex and that Dr Biesgen had been asked to discuss case management with his colleagues I consider his failure to discuss the management of the case to be inadequate.'*

65. In his witness statement, Dr Biesgen stated: *'Contrary to the impression that I needed to discuss matters with others … in this case I did discuss the proposed treatment with Mr Z as the subject of costs of a Smith & Nephew fixator were discussed.'*

66. In his oral evidence Dr Biesgen stated: *'I discussed with Mr Z and decided on this procedure … I treat every patient like a family member.'*

67. The Tribunal has not heard evidence from Mr Z; however, it has already found that there is insufficient evidence to prove that Dr Biesgen was told to discuss cases with senior colleagues.

68. Accordingly, paragraph 2d is found not proved.

<u>Patient C</u>

69. The GMC Expert witness, Mr R, provides a summary of the case of Patient C. Patient C initially attended St Georges PCC/MIU on 3 July 2012 with an injury to his right hand. He gave a history of increasing pain and swelling in his hand following

erection of a fence 2 days previously. He was noted to have swelling over the dorsum of his wrist with tenderness at the base of his 2nd to 4th metacarpals. An x-ray was taken and a provisional diagnosis of a fractured trapezium was made. Following discussion with the hand surgery team, a plaster splint was applied and an appointment made to attend the hand clinic at LGI. Patient C was seen by Dr Biesgen in the hand clinic at LGI on 9 July 2012. Dr Biesgen diagnosed an oblique fracture of the Trapezium and prescribed 'a full cast to the end of the MC (metacarpal) joints'. Dr Biesgen advised review in a further 3 weeks with an x-ray on arrival. Patient C was reviewed by Ms S in the hand clinic on 8 August 2012. She reviewed the x-rays and was of the opinion there was no fracture. She diagnosed tenosynovitis (inflammation of the tendon sheath) as the most likely cause. No further treatment was deemed necessary.

Patient C

20. On 9 July 2012, you consulted with Patient C and you:

e. **incorrectly diagnosed a fracture of the trapezium;** Found Not Proved

70. Mr R was of the opinion that *'Dr Biesgen diagnosed Patient C as having a fracture of the Trapezium. There is no evidence of a fracture on the X-rays taken and therefore the diagnosis was incorrect. It is accepted that interpretation of fractures of the carpal bones can sometimes be difficult and immobilization and review three weeks later would be a reasonable treatment option.'*

71. In his witness statement, Dr Biesgen stated: '*C2/86 clearly indicates that X-rays show "undisplaced fracture of the trapezium, this is demonstrated in the sketcher's view" and that x-rays showed "trapezium fracture". It is clear, despite poor photocopies of the x-rays, that there was a fracture which was "undisplaced" and I described it as "not really dislocated". For someone to say there was no fracture we need to have the clearer x-rays. However, C5/8,10-13 do appear to show a hairline fracture of the trapezium.'*

72. The Tribunal noted that an x-ray report would have been written by a radiologist. Although the Tribunal has not seen the report, it has no reason to disbelieve the record of it made at St. George's PCC/MIU which states: *'there is an undisplaced [fracture] of the trapezium, this is demonstrated on the sketchers view.'* Furthermore, the Tribunal notes that Mr R did not see the original x-rays; he only saw very poor photocopies of them when writing his report. The Tribunal considers that he should have requested the original x-rays and the report. Without better evidence it was unable to say that the trapezium had not been fractured.

73. Accordingly, paragraph 3a is found not proved.

f. **failed to obtain an adequate medical history, in that an adequate history would have ruled out a fracture;** Found Not Proved

74. Mr R is of the opinion that: *'The history is inadequate as to the nature of the Injury and the development of Patient A's symptoms. This would have ruled out a fracture due to the lack of any history of a significant traumatic force which would be needed to cause a fracture of the trapezium. The patient also describes the pain developing gradually which would not be the case in a fracture.'*

75. In his witness statement, Dr Biesgen stated: *'The medical history is within the records (C2/86) and it is not necessary to repeat matters unless there is a correction needed.'*

76. The Tribunal notes that Dr Biesgen's and Ms S's handwritten notes of their examinations on 9 July and 8 August are missing from the evidence bundle. The Tribunal is therefore unable to decide that it was more likely than not that a history was not taken by Dr Biesgen.

77. Accordingly, paragraph 3b is found not proved.

g. failed to examine Patient C's hand and/or wrist to:

iii. evaluate swelling; Found Not Proved

iv. **elicit the area of maximum tenderness;** Found Not Proved

78. Mr R is of the opinion that: *'There is also a lack of documentation of any examination of the hand/wrist to evaluate swelling and elicit the area of maximum tenderness. This would have ruled out a fracture if it had been adequately performed.'*

79. In his witness statement, Dr Biesgen stated: *'The aspect of swelling and tenderness is also in the records (C2/86) and does not need to be repeated and to suggest that I did not examine the patient is incorrect. I was in consultation with the patient, not watching a movie or doing other things. The suggestion that I did not examine the patient is scurrilous.'*

80. The Tribunal does not have Dr Biesgen's handwritten notes, however, there is a diagnosis of a fracture, which could not have been made without an examination of the hand. The radiologist at St George's had reported a fracture; Dr Biesgen saw the fracture on the x-rays and the handwritten notes are missing from Dr Biesgen's consultation with the patient. Therefore, in the Tribunal's judgement it would be unfair to assume that he had not examined the patient.

81. Accordingly, paragraph 3ci and 3cii is found not proved.

h. failed to record:

iii. **an adequate history as to the nature of the injury and the development of Patient C's symptoms;** Found Not Proved

iv. **an examination of Patient C's hand and/or wrist** Found Not Proved

82. Mr R stated that: '*I consider the recording of information relating to the consultation on 9 July to be inadequate.'*

83. In his witness statement, Dr Biesgen stated: *'The history of the patient's injury is within the records (C2/86) and this comment is a repetition of paragraph b. Of course, I examined the patient and any suggestion to the effect that I was involved in extraneous activity is strenuously denied.'*

84. The Tribunal has already noted that at least one page of Dr Biesgen's handwritten notes for this patient must be missing from the bundle. It is therefore unable to say that he did not write a history of the nature of the injury and the development of the symptoms.

85. Accordingly, paragraphs 3di and 3dii are found not proved.

Patient D

86. The GMC Expert witness, Mr R, provides a summary of the case of Patient D. Patient D sustained an injury to her right hand when she tripped over a loose stone in the garden. She cut the ulna border of her right hand at the level of the metacarpophalangeal joint and was seen in the minor injuries unit, St Georges on 30 June 2012, the day of her injury. It was noted by the triage nurse that Patient D suffered with arthritis and as a consequence had some pre-existing loss of flexion in her fingers. An X-ray confirmed a fracture of the base of the 5th metacarpal. Initial treatment was instigated by way of wound cleaning & application of a 'futura' splint and an appointment was made for review at the plastic surgery hand clinic in Leeds (LGI). Dr Biesgen reviewed Patient D on 9 July 2012, approximately 10 days after the injury. Dr Biesgen advised application of a 'full cast' for a further 3 weeks. Dr Biesgen reviewed Patient D on 1 August 2012, 4 weeks after her injury. The cast was removed and a note was made *'full ROM'* (full range of movement). Dr Biesgen deemed that no further follow up was necessary but that hand therapy should continue. A Consultant Plastic Surgeon saw Patient D on 2 October 2012. It was noted by that surgeon that she had suffered *'considerable stiffness* as a result of the hand injury and splintage that had *'largely been overcome with aggressive physiotherapy'.* She now presented with ankylosis of the PIP joints of her ring and

middle fingers and a decision was made to undertake joint replacements to improve mobility and grip. Patient D underwent Swanson arthroplasties to the proximal interphalangeal joints of her right middle and ring fingers on 8 April 2013. Post-operatively she underwent hand therapy and at review on 28 May 2013 was noted to have a reduction in pain, increased flexion at the joints of 15° and improved hand function. At review on 30 July 2013 it was noted that there was little change and a decision was made not to undergo further treatment. Patient D was discharged from further follow-up.

Patient D

21. On 9 July 2012, you consulted with Patient D and you failed to:

d. **arrange an appropriate treatment plan;** Found Not Proved

87. Mr R was of the opinion that:

"The problem we have with patients like this is that by immobilising them in splints for significant periods of time, we may end up with them suffering with more disability after the treatment than they had before. In these sort of circumstances, one has to consider what is going to be best in the long term for the patient….I do not know what the term "full cast" necessarily means in these circumstances… I do not know. I do not know what the splintage was. I have assumed – but I may be incorrect about that – that this means that the cast included the wrist, the metacarpal and the fingers because if you wanted to splint the hand, you would have to include the fingers in it, and that is the problem, that that is likely to lead to a degree of stiffness.
Q Is that the reason why it was inappropriate, because of the previous history of arthritis, it would have led to stiffness?
A If it had been immobilised in a cast of that type, yes…"

88. In his witness statement, Dr Biesgen stated: '*C2/93 clearly states that there was a treatment plan: full cast for another three weeks – four weeks in total and check of the wound in a week.'*

89. In his oral evidence, Dr Biesgen stated that the patient had been referred for physiotherapy.

90. The Tribunal has considered the primary evidence in relation to this paragraph, which is the note at page 93. There is no handwritten note or diagram. Dr Biesgen said that he had anticipated that the plaster cast could be opened in order to check the wound in one week. He was adamant that he had arranged physiotherapy for the patient. This was supported by his note to the GP on 1 August in which he says: '*I have recommended she continues with physiotherapy exercises.'*

On a balance of probabilities, and in the absence of some of the patient notes, the Tribunal agreed that Dr Biesgen's treatment plan involved physiotherapy from 9 July. There was some confusion about what he meant by a 'full cast'; Dr Biesgen in evidence stated that a full cast was placing the hand in the Edinburgh position. The expert was uncertain about what he meant by "full cast" but assumed that it would be a solid case from the wrist to the top of the fingers, in which case physiotherapy would not be possible.

91. Given the likely absence of Dr Biesgen's handwritten patient notes, or any physiotherapy referral notes at all in the bundle, together with the uncertainty about the cast, the Tribunal was not persuaded that Dr Biesgen's treatment plan was inappropriate.

92. Accordingly, paragraph 4a is found not proved.

e. arrange an appropriate referral for post-injury hand therapy; Found Not Proved

93. In his witness statement, Dr Biesgen stated: *'C2/97 states that the patient was treated with "aggressive physiotherapy". Clearly this was stipulated and how one can say that there was no referral for post-injury hand therapy. If notes are missing I cannot be responsible although at C/107 I have clearly stated that "I have recommended that she continues with physiotherapy exercises".*

94. The Tribunal believes that some pages are missing from this patient's records. The note at C2/page 97, however, is not conclusive as it was written on 2 October by Mr AA, a consultant plastic surgeon. Mr AA's letter clearly makes a causal link between putting the patient in a full hand cast for four weeks and the considerable stiffness. Nevertheless, because of the lack of handwritten notes by Dr Biesgen on 9 July and his assertion when giving evidence that he would have referred the patient for physiotherapy, together with the GP letter dated 1 August 2012, in which he says: *'I have recommended she continues with physiotherapy exercises.'*, the Tribunal was unable to say that Dr Biesgen had failed to arrange an appropriate referral for post-injury hand therapy.

95. Accordingly, paragraph 4b is found not proved.

f. make an adequate record of:

vi. **Patient D's medical history;** Found Not Proved

vii. **the nature of the injury;** Found Not Proved

viii. **Patient D's hand dominance;** Found Not Proved

ix. **Patient D's pre-existing arthritis;** Found Not Proved

x. **the limited function in Patient D's fingers** Found Not Proved

96. Mr R in his written report criticised Dr Biesgen for making an inadequate history. In his oral evidence Mr R stated: *'I have said it is not a case of repeating them at every stage. It is a case that this is a referral to a specialist hand surgery unit. The referral is made from a number of different Accident & Emergency Departments. The doctors who see the patients in the Accident & Emergency Department are not so experienced and so skilled in the management of hand injuries, that is why they are referring the patients on for treatment. It is necessary for the doctor who sees the patient at the point of referral into the unit to take an adequate history from the patient of these factors I have mentioned and to record them. It is not difficult. It does not take a long time to do it and it is good medical practice.'*

97. In his witness statement, Dr Biesgen stated: *'Patients medical history is on C2/91; as is the nature of the injury, pre-existing arthritis, limited function of the fingers, although hand dominance is not listed this is a 90-year-old patient and it is interesting to note that although Mr AA picks up on the hand dominance he has not repeated the history which is already there as it is unnecessary to fill the file with repeat information.'*

98. The Tribunal has noted that the relevant history is in the patient's records at C2 / page 91, recorded on 30 June 2012. This records the patient's medical history. On the same page on 30 June it is noted that the patient has known arthritis and reduced flexion, limited function in her fingers.

99. It does not mention her dominant hand; however, the Tribunal believes that some pages are missing from the patient records and therefore cannot be sure that the hand dominance was not mentioned elsewhere.

100. The Tribunal had regard to Good Medical Practice (2006 edition) and in particular to paragraphs 3(f) 3(g) which states:

'3. In providing care you must:

f. keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment;

g. make records at the same time as the events you are recording or as soon as possible afterwards.'

101. The Tribunal notes that the above paragraphs do not require a doctor to repeat records that have been already been made by other health professionals.

102. Accordingly, paragraphs 4ci-v are found not proved.

22. On 1 August 2012, you consulted with Patient D and you failed to:

a. adequately assess Patient D, in that you deemed that no further follow up was necessary, but that hand therapy should continue; Found Proved

b. **make an adequate clinical record, in that you recorded that Patient D had a full range of movement** Found Proved

103. In his witness statement, Dr Biesgen stated: *'The note dictated by me and which is on file, on C2/107, clearly indicates that whilst I have discharged her "I would happily see her again, should she have any problems". Having seen full range of movement it was clear to me that follow up was only necessary, in case of need.'*

104. Mr R said: *'In my opinion given her pre-existing osteoarthritis and the fact that she had sustained a fracture of her 5th metacarpal and had been placed in a splint for 3 weeks I consider this highly unlikely. She subsequently represented some 9 weeks later with complete ankylosis of her middle and ring finger proximal interphalangeal joints despite continuing hand therapy. … a patient presenting with pre-existing arthritis in her finger joints sustains a fracture and has been placed in a splint. When that splint is removed, the hand having been immobilised, it is stated that she has a full range of movement. She then presents some weeks later with stiff ankylosed joints having been out of the splint. That seems to me to be an unusual set of circumstances which are difficult to give a reason why such a thing would occur.'*

105. The Tribunal has taken account of C2/page 107, the letter to the GP in which Dr Biesgen states that the patient had a full range of movement, that her hand was a little swollen and he recommended that she continue with physiotherapy exercises.

106. The Tribunal considered the allegation at 5a and noted that the patient had pre-existing arthritis. The A&E note at C2/page 91 states that she 'usually had reduced flexion'. It accepts Mr R's opinion that, after four weeks in a cast, she could not have had a full range of movement. It follows therefore that Dr Biesgen's assessment could not have been adequate because there was reduced flexion.

107. The Tribunal accepted the opinion of the expert that, because Patient D had pre-existing arthritis and usually had reduced flexion in her fingers, she was highly unlikely to have a full range of movement after the healing of the fracture when the

cast was removed. The Tribunal considers that Dr Biesgen's record at page 95 is very brief and should have made clear how he established that Patient D had a full range of movement.

108. Accordingly, paragraph 5a and 5b are found proved.

Patient E

109. The GMC Expert witness, Mr R, provides a summary of the case of Patient E. Patient E, a right-handed warehouseman, sustained an injury to his right wrist and face when he fell whilst getting out of a van on 27 June 2012. He went to the minor injuries unit at St Georges where he was seen and assessed. He was noted to have a painful right wrist that was swollen and that he was reluctant to move. An x-ray was taken that suggested to the medical practitioner a fracture of the hamate. Patient E was referred to the hand unit and was seen by Dr Biesgen on 11 July 2012. Dr Biesgen confirmed the diagnosis of a fracture to the hamate and advised continuing with the cast for a further 2-3 weeks. Dr Biesgen reviewed Patient E on 2 August 2012 when the cast was removed and a further x-ray was taken. Dr Biesgen stated that the fracture had 'completely healed' and discharged Patient E from further follow up.

Patient E

23. On 11 July 2012, you consulted with Patient E and you:

c. **incorrectly diagnosed a fracture of the hamate;** Found Not Proved

d. **failed to undertake adequate and/or appropriate investigations to make the correct diagnosis** Found Not Proved

110. In his oral evidence, Mr R stated: *'What you have to do is be absolutely sure there is a fracture… most people would do a CT scan to determine whether there was a fracture… In my opinion, this patient did not have a fracture of the hamate so that did not occur, but he was treated in a plaster for a period of time inappropriately… more investigation would have definitively ruled it in or out… The absence of tenderness I think would rule out a fracture… you need the radiology to make the diagnosis… I think routinely, if you were going to treat this nowadays, it would be essential to take a CT scan to delineate the fracture.'*

111. In his witness statement, Dr Biesgen stated: *'The suggestion that there was incorrect diagnosis of a fracture cannot be true for the reason that at St George's say a "lucent line was seen in hamate". That, with respect, can still be seen on X-rays at C5/18,19-22. …C2/113 indicates clearly that I had seen the patient and found an undisplaced fracture of the hamate (clear from the x-rays) and non-*

operative conservative treatment was suggested with cast for further 2/3 weeks and reappointment.'

112. The Tribunal has noted the medical records at C2 page 112, where the radiographer nurse report, states 'fracture of hamate'. The practitioner report on the same page states 'lucent line hamate probable # [fracture]'.

113. Dr Biesgen, appears to have been certain when he reviewed the x-rays that there was a fracture of the hamate. His opinion was more definite than that of the radiographer nurse and the radiography practitioner. Moreover the expert did not see the original x-rays, which the Tribunal accepts showed a lucent line suggesting a fracture. On the balance of probabilities the Tribunal could not find that Dr Biesgen incorrectly diagnosed a fracture of the hamate.

114. Accordingly, paragraph 6a and 6b are found not proved.

Patient F

115. The GMC Expert witness, Mr R, provides a summary of the case of Patient F. Patient F was a 90 year old, right hand dominant male, who presented to the A&E department at LGI on 12 July 2012 having fallen and injured his right arm and hand. He was diagnosed as having fractured the right neck of the humerus and right 4th and 5th metacarpal bases. His humerus fracture was treated by the Orthopaedic surgeons in a 'collar and cuff'. His injured hand was placed in a volar splint and a referral made to the hand clinic. Patient F was seen by Dr Biesgen on 18 July 2012. Dr Biesgen noted that on x-ray there were fractures to the bases of the 4th and 5th metacarpals. He noted the fractures were not dislocated and there was no rotational deformity. He advised conservative management. Dr Biesgen recommended 'a cast for the next three weeks'. He further recorded in the contemporaneous record that: 'A further appointment is only necessary should this [the cast] become loose'. There is also a hand written note dated 18 July that states 'at least 3 weeks cast'. Patient F was reviewed 4 weeks post injury, on 8 August 2012 by Ms S. She noted that the cast had been removed one week previously, and the hand was stiff and swollen. Patient F was given a removable splint, a sling to reduce swelling and referred for hand therapy. Patient F attended for review on 5 September 2012. He was noted to be stiff with reduced movement in both his metacarpophalangeal and interphalangeal joints. The sling and splint were discarded and further hand therapy organised. A final out patient review was undertaken on 31October 2012 at which it was noted Patient F was suffering with significant stiffness of his shoulder. It was considered that no further treatment was needed for his hand and he was discharged from further follow up.

Patient F

24. On 18 July 2012, you consulted with Patient F and you failed to:

c. institute an adequate and/or appropriate treatment plan, to include:

iii. **adequate and appropriate follow up care;** Found Proved

iv. hand therapy Found Proved

116. In his witness statement, Dr Biesgen stated: *'C2/127 suggests that there was a treatment plan: "cast for next 3 weeks" after the consultation on 18/7/12. It appears that the cast was taken off a week early as is suggested by the note (C2/129) of Miss S: "3 weeks is a short time to be splinted" but the cast was removed a week before 8/8/12 that is 1/8/12. It is clear from this that sometimes instructions given were not always followed. C2/126 clearly states that "he has been carrying out exercises with the splint on as advised". I cannot see what the problem is.'*

117. Mr R, in his written report at C2/ page 107 stated: *'The only necessary investigation was an x-ray that was undertaken. There was no operative procedure therefore no pre-operative investigations were required. No operative procedure was performed but Dr Biesgen advised conservative management of the hand fractures by application of a plaster cast for 3 weeks. It appears from the notes available to me that instruction was made for Patient F to return for removal of the plaster cast at 3 weeks without any follow up appointment. The fracture would not have fully united at this stage and would therefore be tender if unprotected. A splint would therefore be required for comfort and to prevent further displacement of the fracture. I consider that in this respect Dr Biesgen's treatment of Patient F was inadadequate and fell below the level expected of a reasonably competent Consultant in Plastic Surgery.'*

118. In his oral evidence, Mr R added: *"the problem… is making sure that again the treatment that you give does not leave him to be in a worse position than he was before he had the accident. I think in this case, that occurred in that the patient did not receive – I do not know again how the hand was necessarily splinted, but certainly by the time the splint was removed some four weeks after the surgery, the patient was stiff and his hand was swollen. Effectively, my understanding is that he did not regain movement, unfortunately, either at his knuckle joints or the interphalangeal joints, so he lost a significant degree of mobility for a relatively simple fracture because he did not receive adequate and appropriate post-operative care."*

119. In cross-examination, Mr R stated: *"I did say the treatment plan was inadequate with respect to the follow-up care… there was a plan for the initial part of the treatment and my criticism was that there was not then a plan to cover what happens when the splint was removed… Is the splint going to stay on forever?... there is no plan. It says "A further appointment is only necessary if the splint*

becomes loose"… that is my criticism, it is the lack of the plan for the follow-up care."

120. The Tribunal considered the medical records from page 116 to 132. Dr Biesgen's letter to the GP is at page 127. His hand written note just describes the fractures and notes 'at least 3 weeks cast, Edinburgh position'. Ms S saw the patient a week later and in her evidence stated: "*The point is that when he was taking out the splint, he should have been referred to physiotherapy and occupational therapy… You would use a removable splint and allow the patient to do controlled exercises so that they would not have the problems with hand swelling and stiffness. You tend not to immobilise elderly patients' hands for long periods of time… The point is that, "A further appointment is only necessary should this become loose", so this patient should not have been discharged and certainly not with a cast."*

121. The Tribunal notes that this patient was 90 years old with a fracture in two fingers. He was obviously in considerable pain, and was given morphine and ibuprofen when he attended A&E on 12 July. Because of his age, he was put on protocol. Dr Biesgen makes no mention of pain relief but this may have been covered elsewhere as Patient F was also being treated for a fractured humerus. Dr Biesgen clearly did not consider a further appointment at the hand clinic to be necessary, the Tribunal accepts the expert's view that Patient F should have been recalled for further evaluation of the hand injury and that he should have been referred for hand therapy. The Tribunal has found that Dr Biesgen had a duty to provide adequate and appropriate follow-up care and failed in that duty.

122. Accordingly, paragraph 7ai and 7aii are found proved.

d. make an adequate clinical record, in that you failed to record:

iv. Patient F's age; Found Not Proved

v. **Patient F's social circumstances;** Found Not Proved

vi. **a history of how the injury was sustained** Found Not Proved

123. In his witness statement, Dr Biesgen stated: *'The age has been redacted from C2/117 but was clearly there for it to have been redacted, social circumstances are on C2/122 and the way the injury was sustained appears on C2/117 "reports tripping". Again, unless there has been some perceived change in the history it is not necessary to keep repeating such aspects.'*

124. The Tribunal has considered the medical records and noted the following:

- Page 116 – states age 90

- Page 117 – states date of birth (redacted)
- Page 124 (multi-disciplinary notes) states how the injury was sustained and the patient's social circumstances

125. The Tribunal therefore finds that the relevant information is contained in the medical records and it was not necessary for Dr Biesgen to repeat it in his record.

126. Accordingly, paragraphs 7bi, 7bii and 7biii are found not proved.

Patient G

127. The GMC Expert witness, Mr R, provides a summary of the case of Patient G. Patient G sustained an injury to his right hand on 12 July 2012 having fallen on his way to collect his newspaper. He was seen In the A&E Department at LGI and referred to the on call plastic surgery team with a diagnosis of a fracture of the right 4th metacarpal. Patient G was noted to be 75 years of age and to have a significant medical history including coronary heart disease, type II diabetes and hypertension. An x-ray confirmed a spiral fracture of the shaft of the metacarpal with a butterfly fragment. A mild degree of rotation was noted. A volar splint was applied and a referral made for review in the hand clinic in one week. Dr Biesgen saw Patient G on 18 July 2012 and advised open reduction and internal fixation of the fracture with a plate and screws. Patient G did not undergo operative fixation of the fracture and was next reviewed in the hand clinic by Ms S on 8 August 2012.It was noted that the hand had been immobilised in a splint for 4 weeks and had developed some stiffness as a result. It was Ms S's opinion that the fracture should have been treated by open reduction and fixation within the first two weeks of injury but that at four weeks the conservative approach should be continued. The splint was reapplied for a further 2 weeks. Patient G was reviewed by Ms S on 22 August 2012 at which time the splint was removed and hand therapy was commenced. He was advised to avoid heavy lifting and told to return for review in a further six weeks.

Patient G

25. On 18 July 2012, you consulted with Patient G and you failed to:

e. follow through with the agreed treatment plan of open reduction and internal fixation of the fracture with a plate and screws; Found Not Proved

128. In his witness statement, Dr Biesgen stated: *'Looking at my dictated notes at C2/137-140 I ask for operation ASAP (C2/137) where I have asked "To List" "as soon as possible" (C2/140). Looking back at it, without additional notes which could easily have dropped off from the loose-leaf filing system or removed, the possibilities include: the 75-year-old patient may not have consented to the operation; or as is*

clear from other operations which appear to have been cancelled by [Ms S] this could have been yet another one cancelled without my knowledge; or I was potentially away for 9 days to Saudi Arabia and then left the unit on 3 August so that the responsibility for carrying out any operations lay with others than me, who was no longer in the unit.'

129. Ms S in her oral evidence stated: *"The problem was that the patient was not put onto the list and the operation was not carried out. That is the problem [D15/96F]… The person who decides that the person needs an operation, ie Mr Biesgen in this case, would have gone around to the pre and post area and put the patient on the list. There is no tray. You do not defer or delegate these jobs. You do it yourself or you ask the plastic surgery registrar to do it. You do not delegate it. It is the responsibility of that surgeon."*

130. Mr R in his oral evidence stated: *"he [Dr Biesgen] made the suggestion but… the patient appears not to have undergone the operation that was suggested… it is the responsibility, obviously, of the surgeon to ensure that if he sees a patient who requires relatively urgent admission to the hospital that he ensures that that patient does get admitted to the hospital. I do not think it is reasonable to say "Well I wrote it down and it didn't happen, that's nothing to do with me". It is the surgeon's responsibility to ensure that if urgent treatment is required that steps are taken to ensure that that occurs."*

131. The Tribunal considered the medical records. Dr Biesgen saw Patient G on 18 July and his notes are at C2 page 137-138. Dr Biesgen's letter to the GP is at page 140. The handwritten note "To List" could not have been written before 24 July when the letter was amended. Ms S and Mr R confirmed that it was the surgeon's responsibility to ensure the patient was put on the operating list. Dr Biesgen said that surgeons had different ways of listing patients such as asking the nurse or telling the secretary or by personally adding to the list. It is difficult to say whether the failure to list this patient was an individual or system failure, in the absence of a clearly written protocol. Dr Biesgen said he had assumed that his plan would have been picked up by the system from his notes and his GP letter or that the nurse in clinic with him would have picked it up to follow through. There is a lack of clarity in how patients were listed for surgical procedures at LGI. There is no doubt that Patient G should have undergone the planned procedure, but the Tribunal was unable to decide who was responsible for this failure.

132. Accordingly, paragraph 8a is found not proved.

f. **arrange Patient G's admission for surgery, having advised Patient G ~~H~~ of the need for surgery;** Found Not Proved

133. In his witness statement, Dr Biesgen stated: *'I had asked for the operation to be listed: See C2/140.'*

134. The Tribunal in finding this paragraph not proved relies on the reasons it has given for paragraph 8a.

135. Accordingly, paragraph 8b is found not proved.

g. discuss with Patient G the reasons for changing the treatment plan; Found Not Proved

136. In his witness statement, Dr Biesgen stated: *'There was no change in treatment plan so there is no need for any discussion but I did inform the patient of the surgery and drew a diagram as appears on C2/138.'*

137. The Tribunal has not been presented with any evidence that Dr Biesgen did change his treatment plan.

138. Accordingly, paragraph 8c is found not proved.

h. discuss Patient G's treatment plan and changes to it with senior colleagues. Found Not Proved

139. In his witness statement, Dr Biesgen stated: *'There was no need to discuss treatment plan with "senior colleagues" as there was no change in treatment plan and this was not a stipulation conveyed to me.'*

140. The Tribunal has already determined that there is insufficient evidence that Dr Biesgen was required to discuss cases with senior colleagues; moreover, no changes appeared to have been made to the treatment plan.

141. Accordingly, paragraph 8d is found not proved.

Patient H

142. The GMC Expert witness, Mr R, provides a summary of the case of Patient H. Patient H presented to the A&E Department at St James University Hospital on 8 July 2012 having injured his left hand when he punched a wardrobe. He was noted to have pain and swelling of his left hand with a rotation and deformity of his fingers and an extensor lag. An x-ray confirmed spiral fractures to the shafts of the middle and ring fingers. A volar slab was applied and Patient H was admitted to the plastic surgery unit at LGI the following day at 09.00. Patient H was reviewed on 9 July 2012 by a plastic surgery trainee who examined him and noted there was no rotational deformity and no extensor lag. The volar slab was replaced and Patient H was advised to keep his hand elevated and given an appointment to attend the hand

clinic as an outpatient in one week. Patient H was seen by Dr Biesgen on 18 July 2012 who noted a 'small rotation of the ring finger' and advised surgery to fix the fracture with a plate and screws. Dr Biesgen informed Patient H of the risks associated with the surgery. Patient H did not undergo surgery and was next reviewed in the hand clinic by Ms S on 8 August 2012. It was noted that his hand was stiff; there was no rotational deformity. He was prescribed hand therapy and the application of a thermoplastic splint. He was advised by Ms S that the opportunity to have the fracture fixed had passed and that he should return for review in 4 weeks. Patient H attended the hand clinic on 31 October 2012 where he was seen by an SpR. It was noted that he had a palpable bony prominence on the dorsum of his left hand and that the head of the 4th metacarpal was prominent in his palm. In view of the fact that his hand function was good and that the fractures were healed he was advised that no further treatment was indicated.

Patient H

26. On 18 July 2012, you consulted with Patient H and you failed to:

e. follow through with the agreed treatment plan of open reduction and internal fixation of the fracture with a plate and screws; Found Not Proved

143. In his witness statement, Dr Biesgen stated: *'The suggestion was to open and fix and C2/158 indicates an operation "asap (as 10 days ago)" clearly indicating an urgency which I was aware of. It seems that the operation was not carried out …'*

144. The Tribunal has considered the medical records relating to Patient H at C2/part 2/143-162. Dr Biesgen's consultation notes are at C2/part 2/158 and 160. His letter to the GP of 24 July says 'surgery as soon as possible'. The operation was listed for 8 August. Ms S saw the patient on that day but by that stage, 4 and a half weeks post injury, it was too late to do the operation.

145. This case is similar to Patient G. The patient notes and GP letter both state that surgery should be as soon as possible. The GP letter was amended on 24 July, after which 'to list' has been handwritten on the letter. Dr Biesgen stated that he expected either the nurse in consultation with him or the secretary would have taken action to list the patient. Whilst both Ms S and the expert said it was the responsibility of the surgeon to arrange the surgery, there was no reason why Dr Biesgen should not delegate that task given that he dictated the letter to his secretary and a nurse was present. It was a reasonable expectation that his instruction would have been picked up.

146. Accordingly, paragraph 9a is found not proved.

f. arrange Patient H's admission for surgery, having advised Patent H of the need for surgery; Found Not Proved

147. In his witness statement, Dr Biesgen stated: *'I had asked for the patient's case to be listed for surgery (see C2/160) "To List".*

148. The Tribunal has taken account of page 144 which is the day surgery unit record and shows the date of admission as 8 August 2012. In finding this paragraph not proved, the Tribunal cites the same reasons it has given in relation to Patient G.

149. Accordingly, paragraph 9b is found not proved.

g. discuss with Patient H the reasons for changing the treatment plan; Found Not Proved

150. In his witness statement, Dr Biesgen stated: *'There was no change in patient treatment plan so there was no need for discussion.'*

151. In finding this paragraph not proved, the Tribunal cites the same reasons it has given in relation to Patient G.

152. Accordingly, paragraph 9c is found not proved.

h. discuss Patient H's treatment plan and changes to it with senior colleagues. Found Not Proved

153. In his witness statement, Dr Biesgen stated: *'There was no change in plan so there was no need to discuss with senior colleagues.'*

154. In finding this paragraph not proved, the Tribunal cites the same reasons it has given in relation to Patient G.

155. Accordingly, paragraph 9d is found not proved.

<u>Patient I</u>

156. The GMC Expert witness, Mr R, provides a summary of the case of Patient I. Patient I was seen by Dr Biesgen at LGI on 19 July 2012. There is a hand written and typed record of the consultation. The recorded history states that Patient I had sustained an injury to her left little finger in 2007 and had undergone repair to her flexor tendons at that time. She had undergone a surgical repair of the tendons and subsequently required further surgery by way of a tenolysis operation on the finger a year later in 2008. When she saw Dr Biesgen, her presenting problem was an inability to move the distal-interphalangeal joint (DIPJ) of her left little finger. Dr Biesgen noted the range of movement in the little finger joints and advised physiotherapy and a further appointment in 4 weeks. Patient I did not attend for the

follow up appointment on 16 November 2012 and was sent a further appointment for 19 April 2013 that she did not attend. She was notified in a letter that it was assumed all was well and no further appointments were made.

Patient I

27. On 19 July 2012, you consulted with Patient I and you failed to:

g. **ascertain what the functional problem was for Patient I;** Found Proved

157. In his witness statement, Dr Biesgen stated: *'Functional problem has been listed on C2/163, repeated at C2/164, where there is a reference to stiffness of the DiP joint 20-20-20 (fixed at 20 degrees as opposed flexibility of 0-30 degrees for normal people).'*

158. In cross-examination, on day 38, Dr Biesgen asserted that Patient I was suffering from complex regional pain syndrome (CRPS) and that physiotherapy could help CRPS. He had not mentioned CRPS either in his hospital notes or in his witness statement, or indeed in his closing submissions. He did not cross-examine the expert about CRPS and therefore the Tribunal places little weight on this evidence.

159. In oral evidence, Mr R stated: *"It was a failure to ascertain what the patient's presenting problem was in the taking of a history… my criticism was that there was a failure to ask the patient, in a sense having suffered with an inability to bend her little finger for four or five years, what was the reason for her presenting: was she having difficulty in some particular function? Was there something which was causing her a problem?... "Why are you coming here to see me today five years after you had an injury and you[r] revision surgery? What do you want? What do you want me to do?"*

160. The Tribunal has considered the medical records at C2/part 2/163-165 and Dr Biesgen's consultation notes at C2/part 2/163-164. It has not been presented with the GP referral letter.

161. The Tribunal is of the view that Dr Biesgen had a duty to ascertain what difficulties the joints was causing Patient I. He listed the symptoms that Patient I was suffering from but not what functions were affected by those symptoms.

162. Accordingly, paragraph 10a is found proved.

h. **record what the functional problem was for Patient I;** Found Proved

163. In his witness statement, Dr Biesgen stated: *'It is clear from C2/163 that the functional problem has been recorded.'*

164. The Tribunal considers that Dr Biesgen had a duty to record what Patient I's problem was; he should have recorded how her past injury affected her day to day life now.

165. Accordingly, paragraph 10b is found proved.

i. **arrange an X-Ray of the stiff joint to determine the nature of the underlying problem;** Found Proved

166. In his witness statement, Dr Biesgen stated: *'I cannot comment on an x-ray which may well have been taken before the patient came to see me but in this case, it is obvious that I examined the patient with regard to stiffness of the joints possibly making it unnecessary for further x-rays to be taken.'*

167. In oral evidence, (on day 38 page 41-42 point G/H), Dr Biesgen stated:

"Q Why did you not send this patient for an x-ray?
A Maybe the patient was already coming with an x-ray. We do not know.
Q Where is your note of the x-ray and your analysis of the x-ray?
A The x-ray is declared stiff because DIP 20, 20, 20 that means stiff.
Q There is no mention of an x-ray in your notes?
A I agree but who told you that he does not walk into the department with an x-ray and where are the x-rays."

168. In oral evidence, Mr R stated: *"My criticism of the care given for this patient relates to the fact that this was a long standing problem and it was likely that the end finger joint was fixed. Physiotherapy would therefore be of no use. An x-ray would have diagnosed if this was the case and would have determined that further treatment was inappropriate. The failure to do this therefore risked wasting valuable resources and the patient's time."*

169. The Tribunal notes that Dr Biesgen did not appear to discount the value of an x-ray. He just produced explanations about the possibility of an x-ray already being taken, although there is nothing recorded in the notes about it. The Tribunal concurs with the opinion of the expert that an x-ray was required, and that Dr Biesgen failed to organise it.

170. Accordingly, paragraph 10c is found proved.

j. **determine an adequate treatment plan;** Found Proved

171. In his witness statement, Dr Biesgen stated: *'On C2/163 there is a reference to the "first option" for a treatment plan being continuous physiotherapy with ball etc exercises also at home for four weeks. This aspect of the treatment plan is repeated on C2/164.'*

172. In his oral evidence, Dr Biesgen stated that he disagreed with the criticism made by Mr R in C9, the supplementary expert report, where he states at page 7: `*my criticism relates to the fact it was a longstanding problem and likely that end finger joint was fixed – if fixed then physiotherapy of no use?'*. Dr Biesgen stated that physiotherapy was not only for mobilisation of a joint as they have a lot of options.

173. In his report Mr R stated: *'No treatment plan was made other than referring Patient I for physiotherapy. ….it would be necessary to investigate the cause of the stiffness in the DIPJ to determine what treatment options were possible. Referral for physiotherapy in the presence of an ankloysed joint would be pointless. I consider that no real treatment plan was made.'*

174. In oral evidence, Mr R stated: *"it was a failure to instigate a treatment plan: "This is what we are going to do. We are going to send you for an x-ray. We will see if the joint is fixed or not. If the joint is not fixed then I will send you to the therapist. If the therapist can get a range of motion in your finger, what we call passive mobility – that is the therapist can get the finger joint to move 45°/50°/60° – then we will consider what we do about that or not as the case may be".*

175. The Tribunal considered that, until Dr Biesgen had identified what was causing the stiffness to the joint, any treatment plan would be purely speculative. He had a duty to devise an adequate treatment plan. Clearly without knowing what was causing the stiffness, Dr Biesgen's referral to physiotherapy could not be considered to be adequate.

176. Accordingly, paragraph 10d is found proved.

k. make an adequate referral to the hand therapist in that:

iii. there was no record made of what you wanted the therapist to do; Found Not Proved

iv. there was no record made of the intended outcome of the proposed treatment; Found Not Proved

177. In his witness statement, Dr Biesgen stated: `*Clearly, I referred the matter to a hand therapist and if such notes are not there in the file or exhibited within these bundles there is nothing that I can do. Explained to the patient how to exercise*

using a ball and referred her to the physio. The treatment plan clearly makes a reference to physio for four weeks.'

178. The Tribunal has considered Dr Biesgen's note of the consultation at page 163 and finds it to be adequate as it contains instructions of what he wanted the therapist to do, albeit brief, namely: 'ball, etc exercises'. Accordingly, paragraph 10ei is found not proved.

179. As to 10eii, there is nothing in the patient records about what the outcome should be; however, there may have been in the referral sheet. In the letter to the GP, Dr Biesgen sets out his clinical observation and states, *'I would recommend physiotherapy'.* He does not state the intended outcome of the proposed treatment. However, the Tribunal can infer from his letter to the GP at page 164 that the outcome Dr Biesgen sought was to achieve better movement in the joints. The Tribunal was informed that referrals to the physiotherapists were made on separate sheets of paper. Whilst the Tribunal has not seen any of these, it could not assume that they did not exist, or that they did not state the intended outcome of the proposed treatment.

180. Accordingly, paragraph 10eii is found not proved.

l. discuss the management of Patient I with senior colleagues
Found Not Proved

181. In his witness statement, Dr Biesgen stated: *'There was no need for any discussion with senior colleagues.'*

182. In oral evidence, Mr R stated: *"This is a case that I might well ask a colleague to look at or most units actually have a forum for discussing these sorts of cases, that they will have a weekly meeting where these difficult cases, these cases where the decision is quite complex. We will discuss them, often bring the patient along, have a group of surgeons look at it and then come to a consensus in terms of the way forward."*

183. The Tribunal has insufficient evidence to prove that Dr Biesgen was required to seek a senior opinion. This was, according to the expert, a particularly complex case. However, Dr Biesgen may not have appreciated it as being complex as there was no urgency to treat immediately.

184. Accordingly, paragraph 10f is found not proved.

<u>Patient J</u>
185. The GMC Expert witness, Mr R, provides a summary of the case of Patient J. Patient J injured his left index finger on 2 August 2012, while he was cutting frozen meat with a knife. He was seen as an emergency in the A&E Department at LGI on

the day of his injury and was noted to have a transverse laceration across the volar aspect of the middle phalanx of his left index finger. He had difficulty flexing the terminal phalanx and a diagnosis of a division of the flexor digitorum profundus tendon was made. Patient J was admitted to LGI on 2 August 2012 under the care of Ms S. On 3 August 2012 Patient J underwent repair of his flexor tendon by Dr Biesgen. The operation was performed under an axillary block. The tendon was sutured with 3/0 and 5/0 prolene sutures. At the end of the operation a cast was applied with the wrist and fingers in flexion. Post-operative written instructions state:

- *'cast in flexion wrist and fingers*
- *Sutures out after 2 weeks*
- *special treatment after Kleinert regime*

Λ

- *physiotherapie [sic] 6 weeks (SO)'*

186. Patient J was discharged on 3 August 2012. No medication was prescribed and no note was made regarding post-operative care and management. There are no further notes available relating to follow up or outcome.

Patient J

28. On 3 August 2012, you operated on Patient J and you failed to:

f. undertake adequate and/or appropriate post-operative checks; Found Proved

187. In his witness statement, Dr Biesgen stated: `*I could not undertake any post-operative checks as the operation was on 3 August, my last day in the Fractures Unit, following which I worked with Prof BB and as such any post-operative checks would be the responsibility of others which, in this case, would be [Ms S].'*

188. In his written report, Mr R stated: *'Adequate and appropriate post-operative checks would include review of the patient following surgery to ensure the traction is correctly applied and that the patient understands how to use it and understands the therapy regime.'*

189. The Tribunal notes that at the time he wrote his report, the expert did not know that 3 August 2012 was Dr Biesgen's last day in work in the trauma unit.

190. In oral evidence, Mr R stated: "*There is conflicting information relating to what the surgeon has put down in his operative note or post-operative care, i.e. Kleinert mobilisation. What we all understand by Kleinert mobilisation – and I have just described that – and the fact that the patient appears to have been placed in a volar splint and then discharged without referral to the hand therapy unit. If the tribunal accepts the evidence of the latter – that the patient was placed in a volar splint and discharged without appropriate and by appropriate I mean referral to the*

hand therapy for a proper splint to be applied, a Kleinert traction splint to be applied, within the first 24 to 48 hours – then I consider that the treatment was inadequate and inappropriate. …From the information that is made available to me in the notes and the issues that we have discussed, there is not any evidence that the surgeon undertook what I would call adequate or appropriate post-operative checks… it is the responsibility clearly of the surgeon to ensure that before a patient is discharged home that the correct treatment plan is in place, either himself or a member of his junior team. So there is not any evidence regarding post-operative checks."

191. Mr R further explained: "*One issue is the timing of starting the Kleinert regime, which we discussed this morning and stated that this should be started early, within 48 hours. Secondly, it is the fact that Ms S states that the patient was placed in a volar slab; that means a cast which is placed on the palm or flexor side of the forearm and hand which of course would prevent it from moving, so it would not be possible to commence the Kleinert traction or any degree of mobilisation with the patient in a volar slab… most surgeons in these circumstances would apply a dorsal cast rather than a volar slab because the hand would be placed in a position with the wrist flexed and the metacarpal phalangeal joints flexed to protect the tendon repair. Placing a patient in a volar slab would be very unusual. It would of course mean he would not be able to mobilise it because the fingers would not be able to bend because the cast would prevent them from doing so… You do not normally place a patient in a volar slab when you are using mobilisation for a flexor tendon repair."*

192. The Tribunal has taken account of the medical records at C2/part 2/166-178 and Dr Biesgen's operation notes at C2/part 2/175. It has taken account of Ms S's oral evidence on Day 15 page 18 B where she said: *'The nurses told me that this patient was placed in a volar slab and can be corroborated by the physiotherapist who saw the patient when we had to bring the patient back as an emergency to start appropriate physiotherapy after this injury. …'*

193. Dr Biesgen asserted that, because he had written 'Kleinert regime' in his operation note, the staff should have understood what was required. However, LGI did not use the Kleinert system and, Patient J was discharged in accordance with Dr Biesgen's instructions that after the cast was applied, the next action would be sutures out after two weeks. The Tribunal considered that Dr Biesgen had a duty to ensure that the staff understood what he meant by 'Kleinert'.

194. Dr Biesgen undertook the operation; he wrote some instructions which were not in chronological order and which clearly confused the staff.

195. The Tribunal accepts that Dr Biesgen was not working in the Trauma department after 3 August; however, as the treating surgeon he had a responsibility to check the patient before he was discharged. If Dr Biesgen had checked the

patient prior to discharge then he would have noticed a volar slab had been applied which would not have facilitated a Kleinert regime. The Tribunal found on a balance of probabilities that Dr Biesgen failed to undertake any post-operative check of Patient J.

196. Accordingly, paragraph 11a is found proved.

g. arrange an adequate and/or appropriate treatment plan post-operatively; Found Proved

197. In his witness statement, Dr Biesgen stated: *'… as is clear from the comments during the course of the cross-examination of Mr R, he withdrew his criticisms as the operation notes C2/175 clearly state "Kleinert Regime", which includes physiotherapy for six weeks, post operatively. The Kleinert Regime is an established system which is well known and, whilst there may be minor derivatives, the overall principle is to mobilise within 24/48 hours of the operating procedures, and that remains.'*

198. In oral evidence, Mr R stated: *"There is no information regarding adequate or appropriate treatment post-surgery and there is not any evidence of what arrangements were going to be made about post-operative monitoring, although I would accept that in that circumstance that if the patient had been adequately referred for hand therapy it was probably the hand therapist who would then continue their care. So if the patient was sent home in a volar slab with no arrangements made for their mobilisation post-operatively, then I would consider the treatment was inadequate and inappropriate."*

199. The Tribunal has noted Dr Biesgen's treatment plan as set out at page 175 in the medical records. He did not arrange for the patient to return in order to apply the Kleinert within 48 hours. The confusion of his treatment plan was such that the patient ended up in a volar slab and Dr Biesgen did not indicate a timetable for the patient to be seen again other than for sutures to be taken out in 2 weeks. There was also ambiguity in terms of the prescribed physiotherapy. It is obvious that the staff also found it confusing as the patient was discharged with the wrong type of protection (volar slab) and without having the Kleinert or equivalent system arranged.

200. Accordingly, paragraph 11b is found proved.

h. make an adequate and/or appropriate referral for post-operative hand therapy; Found Proved

201. In his witness statement, Dr Biesgen stated: *'Post-operative hand therapy is clearly indicated on C2/175, … and although Mr R withdrew his criticisms then reinstated them for reasons which have yet to be clarified, the fact is that based on the documents before him the criticism is not valid. When asked to clarify my writing*

I did clearly indicate that there was another document – a referral to the physios – who were not in the room adjoining the theatre.'

202. In his submissions Dr Biesgen stated that: *'Kleinert regime is universally recognised and there is no need to spell out what is required.'*

203. In his written report, Mr R stated: *'A referral to the hand therapist would be considered essential for a patient undergoing flexor tendon repair. Failure to make a postoperative referral to the hand therapist outlining the treatment plan to be followed would be considered inadequate and inappropriate.'*

204. The Tribunal has found that Dr Biesgen did not undertake the post-operative checks and allowed the patient to be discharged without making the proper arrangements including hand therapy. Whilst he thought he had made an adequate referral, in reality, he had not, as his plan was not clear to others.

205. Accordingly, paragraph 11c is found proved.

i. ensure adequate and/or appropriate post-operative monitoring; Found Not Proved

206. In his witness statement, Dr Biesgen stated: *'I could not ensure adequate and/or appropriate post-operative monitoring as 3 August was my last day in the Fractures Unit and any post-operative monitoring was the function of others.'*

207. In his written report, Mr R states at page 148: *'Dr Biesgen did not ensure adequate and appropriate postoperative monitoring of Patient J.'*

208. The Tribunal only has Dr Biesgen's operative note. It has considered the wording of the charge and was unable to distinguish what is meant by post-operative monitoring in the context of the preceding sub-paragraph. The issue was never adequately aired in evidence. The expert had assumed that Dr Biesgen had continued to work in the Trauma unit after 3 August 2012, but this was not so, as 3 August was his last day. Given the uncertainty of what this allegation means, the Tribunal must find it not proved.

209. Accordingly, paragraph 11d is found not proved.

j. keep adequate and/or appropriate notes of the consultation. Found Not Proved

210. In his witness statement, Dr Biesgen stated: *'There are adequate notes of the consultation on C2/175.'*

211. In his written report, Mr R stated: *'From the notes available to me it appears that Dr Biesgen only saw Patient [J] on one occasion ie on the day of surgery. There are no notes of the consultation and therefore no recording of the history of the injury and the examination of Patient [J].'*

212. The patient had reported to the LGI Emergency Department on 2 August 2012 and Dr Biesgen operated on 3 August. There is no evidence that Dr Biesgen consulted with him at all.

213. Accordingly, paragraph 11e is found not proved.

Patient K

214. The GMC Expert witness, Mr R, provides a summary of the case of Patient K. Patient K sustained an injury to his dominant left hand on 29 July 2012. He was seen in the A&E department at LGI and was diagnosed with a 'Bennetts' fracture of the base of his thumb. He was referred to the specialist hand surgery unit. Patient K was seen by the hand surgery team on 2 August 2012 and a plan was made for the fracture to be reduced and fixed with a percutaneous K wire. Dr Biesgen performed the procedure on 3 August 2012. Rather than performing a closed reduction of the fracture and percutaneous fixation he undertook an open reduction and fixed the fracture with two buried K wires. Ms S reviewed Patient K on 31 August 2012 and noted that the x-rays showed that the fracture had been inadequately reduced and fixed. Arrangements were made to remove the K wires and attempt to reduce the fracture. It proved impossible to completely reduce the fracture as it had already united; however, some improvement was gained. An x-ray on 12 December 2012 confirmed the fracture to have healed in a mal-united position with loss of the congruity of at least 25% of the joint surface at the base of the 1st metacarpal.

Patient K

29. On 3 August 2012, you operated on Patient K and you failed to:

f. **adequately reduce and fix Patient K's fracture;** Found Proved

215. The Tribunal has taken account of the medical records at C2/part 2/179-218 and Dr Biesgen's operation notes at C2/part 2/189.

216. In his witness statement, Dr Biesgen stated: '*I refute this for the following reasons: CC was operating on an adjoining table and saw precisely what I had done. If there had been anything untoward this would have been noted. I have made such observations since before the first IoP hearing on 8 October 2014. Had the GMC wished to corroborate it could have done so in over three years since that date. It could at least have checked for fact if CC was in attendance, from the op lists.'*

217. Dr Biesgen has asserted that he operated in the same room as CC; the Tribunal is of the view that the onus was on Dr Biesgen to call CC if he wanted to prove his assertion.

218. Ms S stated in her evidence that the fracture had not been adequately reduced or fixed. Page 218 shows her consultation notes of 31 August in which she reviewed an x-ray that showed the fracture had not been reduced and was unstable. As a result she operated to remove the k-wires. She manipulated the thumb but was unable to improve the fracture position. The operation note stated that the fracture site was rigid and therefore a decision was made to accept the position.

219. In cross-examination, Ms S explained: *"… the procedure carried out by Mr Biesgen on 3 August had not adequately reduced the fracture, so the fracture was still not reduced; however, there were k-wires placed in a fracture that had not been properly reduced. So there was still disruption of the joint surface of the bone…".*

220. In his written report, Mr R states: *'Dr Biesgen failed to adequately reduce and fix the fracture. The advantage of performing an open reduction is to achieve good reduction of the fracture. There is a record in the operation note that x-rays were taken during the operation. These are not available to me and therefore it is not possible to determine whether it was adequately reduced but then inadequately fixed.'*

221. Whilst Mr R was uncertain of the date on which the x-rays had been taken, the Tribunal's copy in C5 pg 142 and 143 had the date of 31/08/2012 at the bottom of each x-ray. Mr R was unable to read the photocopies of the small x-rays that had been taken of this patient. However, he was able to comment on the ones that had been taken when the patient came to see Ms S on 31 August.

222. The Tribunal considers there was clearly a duty on Dr Biesgen to adequately fix Patient K's fracture. It accepts the evidence presented by Ms S that the fracture had not been adequately reduced and fixed.

223. Accordingly, paragraph 12a is found proved.

g. arrange an X-Ray to confirm adequate fixation of the fracture;
Found Not Proved

224. In his witness statement, Dr Biesgen stated: *'I carried out three x-rays: anterior, posterior and lateral. Had the x-rays been unclear I would have repeated them. I have absolutely no doubt in mind that the x-rays were clear but those in the bundle are of atrocious quality (see C2/215 and C5/212), with no dates as to when taken.'*

225. He went on to state: *'I did arrange proper x-rays. Those that appear on C2/215 are not clear and I am certain that those that I took were clear and would clearly show the k-wires which are not apparent from these x-rays. I am certain that better copies of those that I took exist as they do not degrade over such a short period.'*

226. In his written report, Mr R states: *'Following fracture fixation it would be appropriate to x-ray the injury to confirm that adequate fracture reduction and fixation have been achieved. I am unsure whether x-rays were taken during the operation. There is a note in the operative record that states 'x-rays ap + lateral'. There are some photocopies of per-operative x-rays in the hospital notes but these are small and I cannot read the date. I am unsure whether they relate to the operation performed by Dr Biesgen on 3 August 2012 or the operation by Ms S on 31 August 2012. Due to the size and quality of the copy I am unable to read the x-ray.'*

227. In view of the expert's uncertainty as to whether x-rays had been taken, the Tribunal was unable to find this paragraph proved.

228. Accordingly, paragraph 12b is found not proved.

h. **determine that the fracture was adequately treated;**
Found Proved

229. In his witness statement, Dr Biesgen stated: *'I did determine that the fracture was adequately fixed. CC saw it and, if proper x-rays are provided, I am confident that they would prove my case. On C2/189 the drawing clearly indicates how it was fixed.'*

230. The Tribunal has already found that as Dr Biesgen failed to adequately reduce and fix Patient K's fracture, he could not possibly have determined that the fracture was adequately treated.

231. Accordingly, paragraph 12c is found proved.

i. discuss the management of Patient K with senior colleagues;
Found Not Proved

232. In his witness statement, Dr Biesgen stated: *'I did not need to discuss management of patients with anyone although on this occasion CC was there and saw the fixed thumb so that one could arguably say there was "discussion".'*

233. In her account to the business manager, following a complaint by the patient, Ms S wrote: *'Although the patient was nominally under my care, Mr Biesgen did not*

discuss the case with me preoperatively and I was unhappy that he had operated on a patient of mine without having had the courtesy to discuss this with me first.'

234. The Tribunal has already determined that there is no direct evidence that Dr Biesgen was required to discuss the management of Patient K with senior colleagues. Moreover, it notes from the evidence heard that dealing with a Bennett's fracture is a fairly straightforward procedure.

235. Accordingly, paragraph 12d is found not proved.

j. record any details of a pre-operative meeting with Patient K
Found Not Proved

236. In his witness statement, Dr Biesgen stated: *'Any pre-operation notes were meant to have been made by [Ms S] as she saw the patient on 2 August according to the report of Mr R.'*

237. In his closing submission, Dr Biesgen states that the pre-operative notes are at pages 182-193 of the bundle. None of these records detail a pre-operative meeting with Patient K. Consent was taken by a FY2 on 2 August 2012. There is no record of Dr Biesgen having any pre-operative meeting with Patient K.

238. The Tribunal noted that the medical notes for Patient K were not collated in a logical order.

239. In his report, Mr R states: *'Dr Biesgen did not record any information of his pre-operative meeting with Patient K on the morning of the surgery. I consider a failure to record any information to be inadequate.'*

240. The Tribunal found no record of a pre-operative meeting with Patient K in the bundle. Dr Biesgen's submissions, that the pre- operative notes were at pages 182-193 were completely unhelpful to the Tribunal: page 182 is an undated multi-speciality assessment record that states Ms S was the consultant on-call; page 193 is a pre-operative verification checklist which Dr Biesgen has signed confirming the presence of the correct patient, marking of the correct site, procedure to be performed. The Tribunal observed that the pages of the bundle that refer to Patient K were out of chronological order and confused; for example, page 205 is followed by page 217. It could therefore not be sure to the required standard that Dr Biesgen did not have a meeting or record details of it.

241. Accordingly, paragraph 12e is found not proved.

<u>Patient L</u>
242. The GMC Expert witness, Mr R, provides a summary of the case of Patient L. Mr W was the consultant on the on-call trauma service at Cambridge on 10 October

2012. He reports: *"Patient [L] had caught his right thumb in a mechanism whilst he was mowing the lawn… the thumb had no blood supply due to the injury and that it was hanging off by tissue and bones were exposed… I did not examine the patient myself as it was clearly something that needed surgical intervention and exploration without delay".* Mr W left Dr Biesgen to carry out the operation and told him to contact him if he had any issues. Dr O admitted and reviewed Patient L during an on-call shift in A&E on the evening of 10 October 2012.

Patient L

30. On 10 October 2012, you operated on Patient L and you failed to record:

d. details of the circulation in Patient L's thumb at the end of the operative procedure Found Proved

243. The Tribunal noted that the operation began on 10 October 2012 and finished in the early hours of 11 October 2012.

244. Mr R found that your technical approach to the surgery appeared to be adequate and appropriate: *'Dr Biesgen's technical approach to the surgery in terms of the fixation of the bone, the tendon repair and skin closure appears adequate and appropriate apart [sic]. However there is no documentation about the status of the digital arteries apart from the fact that they are intact. It is well accepted that intact arteries can still fail due to intimal damage that is not uncommon in these types of injuries'.*

245. Mr R also stated that: *'No note is made of… the status of the circulation within the thumb upon completion of the surgery… I consider the failure to record the status… of the circulation in the thumb following release of the tourniquet falls below the standard expected of a reasonably competent Senior Registrar in Plastic Surgery.'*

246. In his witness statement, Dr Biesgen stated that the allegation is incorrect and: `*The fact is that: there was perfusion that I was able to not only see but have photographs on my phone, which have been produced during the hearing; W had confirmed that he was satisfied that there was no indication of mal-perfusion of the thumb; … had there been mal-perfusion I would have noted down any such case;'*

247. In re-examination Mr W stated: *"I think it would have been nice to see something that said, "When the tourniquet was down the thumb went pink". That actually has not been written… To have seen somewhere written in the notes, "On release of the tourniquet the thumb was pink" or "The thumb was pink at the end of the procedure". I think that would have been nice to have seen… as you quite rightly point out, it is not written down that it was… It would have been useful to have had a little bit more detail about the circulation at the end of the procedure. We have detail the following day that there was circulation."*

248. The Tribunal has considered Dr Biesgen's medical notes in relation to Patient L are at page 265 and 266. There is no record of circulation in the patient's thumb at the end of the operation. At the end of re-examination, Mr W accepted that there should have been more detail about circulation recorded in the notes.

249. Accordingly, paragraph 13a is found proved.

e. **the status of the circulation in the arteries;** Found Proved

250. Mr R stated that: *'the failure to record the status of the circulation in the arteries… falls below the standard expected of a reasonably competent Senior Registrar in Plastic Surgery.'*

251. In his witness statement, Dr Biesgen stated: '*the operation notes C2/266 record the fact that the thumb had to be observed hourly; and Mr W, in evidence, had confirmed that the duty of such observations shifted to the junior doctors and the nursing staff who were adequately trained to check for circulation.'*

252. The Tribunal has noted that the operation concluded at 1.30am on 11 October 2012 and that Dr Biesgen made his entry at 08.30am on the same day. Mr R gave extensive evidence of the means by which a doctor could check the status of the circulation in the arteries. It notes that Dr Biesgen records that the arteries are intact but he has not recorded the state of the circulation in the arteries. Mr W also opined that the subsequent failure of the arteries was as a result of intimal damage. The Tribunal accepts the expert's opinion that Dr Biesgen should have recorded the status of the circulation in the arteries.

253. Accordingly, paragraph 13b is found proved.

f. the use or time of a tourniquet Found Not Proved

254. In his oral evidence, on Day 3 page 45 Mr W stated: *"It would be usual to document the length of time the tourniquet was used and it may be that somewhere else in the notes, often in the anaesthetic chart, it would document tourniquet up, tourniquet down … normally as a surgeon I would myself record the length of tourniquet for any limb procedure."*

255. Mr R stated that: *'no note is made of the use or time of the tourniquet'*.

256. In his oral evidence, Mr R stated: *"… it is a normal thing to be noted in an operative note, "Tourniquet has been applied"… it is important to document the tourniquet time… Normally, you put tourniquet time, an hour, an hour and a half, two hours, two and a half hours, but you would normally record that sort of information."*

257. In his witness statement, Dr Biesgen stated: *'With regard to the use or time of tourniquet, C2/262 shows the tourniquet was applied at 0004 and removed at 0100 so that it was on for 56 minutes. Such a record is made by the anaesthetist as I was unable to do so whilst operating with the operation taking a further two hours plus with C2/267 showing that I was not free from the operation until 0325 so would not be in any position to make such records, which fall to others to note.'*

258. The Tribunal noted that both Mr W and Mr R stated that they made a point of recording the tourniquet times themselves. However, the Tribunal observed that the anaesthetist chart recorded the tourniquet up and down times. The Tribunal was satisfied that this was sufficient to act as a record and therefore there was no failing on Dr Biesgen's part.

259. Accordingly, paragraph 13c is found not proved.

Patient M

260. The GMC Expert witness, Mr R, provides a summary of the case of Patient M. Patient M sustained a laceration to her left arm on 5 October 2012 that was initially managed in the A&E Department at Hinchingbrooke Hospital. She was reviewed at Addenbrookes Hospital by the on-call plastic surgery team the following day, and an arrangement was made for Patient M to be admitted for surgical exploration on 9 October 2012. This was delayed until 12 October 2012, as Patient M was ill. Patient M was admitted at 07.30 and prepared for operation. However, she was informed at 14.30 that there was no time for the surgery and was discharged home and asked to return on 15 October 2012. On 15 October Patient M was seen by Dr Biesgen who initially informed her that due to the complexity of the list he would not be able to perform her surgery. However, after intervention by a member of the nursing staff, he agreed to continue. The operation was performed by Dr Biesgen on 15 October 2012 and afterwards it was reported to Patient M by a member of the nursing staff that the only injury was to the Palmaris longus tendon that did not require repair. Patient M continued to suffer with numbness of her thumb and index fingers and inability to oppose her thumb. Following review by Mr T, Patient M was readmitted to Addenbrookes and underwent secondary exploration on 16 November 2012 at which time it was discovered she had sustained a partial division of the median nerve and division of the palmar cutaneous branch of the median nerve. Patient M subsequently required further surgery under the care of Mr T. She required long term hand therapy and continued to experience altered sensation in the thumb and index finger.

Patient M

31. On 15 October 2012, you operated on Patient M and you failed to:

d. identify the injury to the main trunk of the median nerve;
Found Proved

261. In his witness statement, Dr Biesgen stated: *'The comments that may be appropriate are: that by the time I operated it was 10 days after the injury and as such well after the optimum time for repair which is up to 72 hours from the injury, as covered in literature, which was covered during the cross-examination of Mr R; I noted that the median nerve was intact (middle of page C3/1) but also noted that there were scars from the injury in the nervus medianus which is part of the process of healing that has already taken place by the time I operated but I recall doing a couple of sutures over it which would be noted on the second page of the notes or the reverse of the page copied. …. There was no apparent injury to the main trunk of the median nerve other than a small cut to which I applied a couple of sutures at the beginning of the neuroma'*

262. In the hospital's response to Patient M's complaint, dated September 2014, the patient was informed as follows: `*Regarding Dr Biesgen's competency, every other trainee with the reported experience of Dr Biesgen... would be expected to be fully competent to deal with a clinical case such as yours at the end of their training… It is Mr T's opinion that an injury to your median nerve was missed at the time of your initial surgery. This should have been suspected from the history, mechanism of injury and examination. Repair of the laceration would not necessarily have produced a better clinical outcome but it could have done so.'* [C2/part 2/40].

263. In oral evidence Mr U stated:

'From the evidence in front of me, the evidence that I have appears to confirm that you were the surgeon who operated on 15 October and the evidence that I have seen suggests the patient did indeed have injury to the median nerve prior to that operation. From the medical record, you are clearly documenting a sensory loss at that time and that would therefore suggest that you did not identify the median nerve injury at your operation on 15 October [D4/59C-D]… that note is quite clear: the median nerve was not repaired on that date [D4/62H]…

I am entirely satisfied, both from the copy of the operation note that I have seen, by virtue of an electronic scan – because the original has disappeared – and also my recollection of the clinical process at the time, that at the time, having stated to clinicians that the nerve was not repaired, that led to the decision to reexplore the nerve in the November operation. I am entirely clear in my mind that the nerve was not repaired on 15 October [D4/65F-G].'

264. Similarly, in oral evidence Mr T stated: *'I can remember seeing that nerve and there was no sutures in it when I looked …'*

265. The Tribunal has considered the medical records relating to Patient M at C2/part 2/322-532. These appear to be out of order. The operation note itself is at C3.

266. Dr Biesgen asserted that there was a second page to the operation note at C3. The Tribunal considered this and compared C3 with other operation notes that he had written. The layout of C3 appears complete compared with Dr Biesgen's other operation notes. The Tribunal therefore rejected Dr Biesgen's assertion. C3 makes two comments about the median nerve; the first says:

'N. medianus; has seen some older scars….. close to the area of the cut! (injury before ???)'

267. Halfway down the operation note Dr Biesgen has written:

> ' – *inspection N medianus left intact!'*

268. The Tribunal has also noted Patient M's evidence, in which she states that after the operation she was told that: *'I was told by one of the nurses …that during the operation, they hadn't discovered any damage to my hand…I do not recall the nurse mentioning anything about the median nerve.'* The Tribunal accepted her evidence, together with that of Mr T and Mr U that Dr Biesgen had not identified the injury to the main trunk of the median nerve.

269. Accordingly, paragraph 14a is found proved.

> e. **identify the injury to the palmar cutaneous branch;** Found Proved

270. In his witness statement, Dr Biesgen stated: *'The injury to the palmar cutaneous branch is not noted on the first page of my notes (C3/1) but I believe that it would have been on the second page of my notes which appear not to have been produced. The fact is that I did not repair this because this is a superficial branch, as stated in literature and apparently confirmed by Mr T, that the outcome of repairing this is of not much consequence.'*

271. The Tribunal considered the operation note at C3 and observed that there is no reference to the palmar cutaneous branch. Dr Biesgen's assertion is that he had noted it on a second (missing) page of the record. However, the Tribunal has already determined that C3 is a complete record of the operation and there is no missing page. Furthermore, Mr T and Mr U stated that the palmar cutaneous injury was not identified by Dr Biesgen when the patient was re-explored in November.

272. The operation notes from that re-exploration state under findings:

'palmar cutaneous (N) 100% divided
➔ ends identified

Procedure
…
PCN repaired 8/0 nylon'

273. The Tribunal has taken account of page 342, the letter from Mr T to the patient's GP dated 29 January 2013, which describes the re-exploration of the injury that took place on 16 November 2012. He said *'she had complete division of the palmar cutaneous branch of the median nerve which was repaired.'* The Tribunal accepted the evidence in the operation note and that given by Mr T.

274. Accordingly, paragraph 14b is found proved.

f. ~~**record an operation note.**~~ Has been withdrawn By the GMC

275. Accordingly, paragraph 14c is deleted from the allegation.

Patient N
276. The GMC Expert witness, Mr R, provides a summary of the case of Patient N. Patient N was admitted on 20 November 2012 following an out-patient appointment for review of his left leg. He had undergone the amputation of his leg having sustained polytrauma some weeks previously. Patient N was noted to have an infection of his left thigh and was admitted for drainage of this. Washout and insertion of a drain was undertaken on 21 November 2012. The planned procedure on 23 November 2012 was a 'second look' to review the status of the wound and to proceed to closure if appropriate. The case was listed on the daily 'Plastic Surgery Trauma List' commencing in the morning around 08.30. The surgical team was rostered on a weekly basis and consisted of a registrar and SHO. On occasion it also included a Consultant. On 23 November the team comprised Dr O (SHO) and Dr Biesgen (Senior Registrar). Dr Biesgen operated on the first patient on the list but then became unavailable. This necessitated the operating list being suspended for a period. Dr Biesgen stated he had been revising for an upcoming exam in the theatre offices. However, Dr O stated that she looked in all the theatre offices and could not find him. She also called him several times on his mobile phone without success. Dr O stated that Dr Biesgen did not assist with the surgery and advised Dr O to close the wound without examining it to deem if it was appropriate to do so. Dr O stated that she performed the procedure on her own and was not aware that Dr Biesgen had left the operating theatre without informing her where he could be contacted if assistance was needed.

Patient N

32. On 23 November 2012, you:

d. **were not contactable between 10:00 and 11.40 despite having primary responsibility for patient care;** Found Not Proved

277. In his witness statement, Dr Biesgen stated: *'it is clear that I was not expected until 1100 - this is stated in the notes of the meeting with Mr T on 7/12/12 "failing to return to theatre at the agreed time of 1100" (C2/25) where "I was not feeling well so went to the 11am meeting" (C2/26) – so that the expected procedure was at 1100 and not 1000; I was fifteen minutes late "kept them waiting for 15 minutes" (C2/25) although Mr T felt that it may have been 20 minutes (C2/25); C2/15 indicates that the agreed time for the meeting was 1100; C2/584 shows that I was in the theatre scrubbed up and ready for the operation at 1136 and it would take me a good 15/20 minutes of prep time to include the pre-op meeting, bringing the patient in the correct position, scrubbing up etc so that there is no way that I was away until after 1140. It is clear that I could have been 15/20 minutes late …'*

278. Dr O describes in her witness statement: *'On this particular morning I can remember the theatre staff trying to contact Dr Biesgen on his telephone and there being no answer. I can also recall that I looked in the theatre offices for Dr Biesgen and he was not there… I can recall that I looked in the office by the emergency theatre by theatre 20 and 21 and I also looked in the main theatre coffee room. I looked in all three theatre rooms and did not see Dr Biesgen… I also tried to call Dr Biesgen on several occasions that morning; however he was not answering his telephone… the List was his responsibility and he should have been present.'*

279. In her oral evidence (Day 4 page 4) Dr O stated that on this day, four patients were listed. She said that the operation on the second patient should have started after the first patient had concluded (before 10am). She was unable to contact Dr Biesgen on his mobile phone and he did not have a bleep.

280. Dr O complained to Mr EE and Mr T that Dr Biesgen had left theatre and was not contactable between 10am and 11.40am. The matter was raised at a meeting held on 7 December 2012 and the allegation was put to Dr Biesgen who stated: *'it is correct that I kept them waiting for 15 minutes. I had to be in medical staffing at 11am for an appointment to discuss my application. I apologised.'*

281. It appears to the Tribunal that at the meeting Dr Biesgen was equivocal in what he said, for example, about always seeing patients prior to surgery. The Tribunal has considered the operating lists and their timings contained therein.

282. The Tribunal considered whether there was a duty on Dr Biesgen to be contactable from the end of the first operation until the start of the second operation (10am to 11.20am). It took account of the expert opinion of Mr R who stated: *'Dr Biesgen as the senior surgeon should have been contactable at all times during the list on 23 November 2012. Failure to ensure easy and rapid contact availability*

during an operating list for which you have primary responsibility would be considered to fall below the level expected …'

283. The Tribunal accepted that it was Dr Biesgen's responsibility to be contactable throughout the operative list. The first operation, at which Dr Biesgen was present concluded at 09.46. The Tribunal found that Dr Biesgen had then left the theatre. He said he was revising for an exam in the theatre offices and that he had visited medical staffing. He was at the Team brief which concluded at 11.36am or 11.40am, according to the record. The incident report form at C2/part2/page 15 stated that Dr Biesgen had kept the theatre team waiting for 20 minutes after he failed to return to theatre at 11am and that the staff were unable to contact him. The Tribunal concluded that Dr Biesgen was not contactable from 10am to 11.20am. However; he had become contactable after 11.20am and therefore the strict wording of the allegation cannot be met.

284. Accordingly, paragraph 15a is found not proved.

e. **failed to assess the wound on Patient N's thigh before instructing a junior doctor ('Dr O') to close the wound;** Found Proved

285. In his witness statement, Dr Biesgen stated: *'C2/559 shows consultant DD and SpR FF have listed the procedures of assessing/cleaning and VAC dressing prior to the closure of the wound so it has been assessed by them on 21/11/12. C2/549 represents notes of Consultant DD and signed by [Dr O] to say that she was aware of the procedures expected of her; Full assessment of the wound prior to closure is detailed on C2/558 (as "swab taken/washed out/assessed wound as being healthy, minimal debridement of the wound edges and closure"), so that it is nonsense to say that the wound had not been assessed.'*

286. In her witness statement Dr O confirms that: *'The plan recorded in the medical records was to explore the wound and determine whether it was healthy enough to close. Whilst Dr Biesgen could have assessed the wound visually without putting on any gloves or scrubbing, I recall that he had already made the decision to close the wound prior to reviewing it… I do recall that he specifically asked me to close the wound, before we had even commenced the operation or inspected the wound. I therefore closed the wound in layers and Dr Biesgen left the room before I had finished the closure… I would have expected Dr Biesgen to have scrubbed for the operation and to have explored the wound or observed my exploration of the wound before he made a decision whether or not the wound looked healthy enough and should in fact have been closed at that time.'*

287. In his written report at page 191 para 5.2, the expert criticised Dr Biesgen for failing to assess the wound before instructing the junior surgeon to close the wound.

288. In his oral evidence, Mr R was asked why it was incumbent on the supervising surgeon to carry out an assessment of the wound before closure. He responded:

"This was what we would term a chronic wound on the thigh. There had been previous surgical procedures. The wound had been inspected on a previous occasion so a decision was being made to surgically close the wound. It is important, obviously, when you are closing an established wound – that is not a fresh direct wound – to ensure that there is no significant infection in the wound when you close it, because if you do close a wound that is infected, if there is a lot of debris within the wound, then there are obviously risks of developing serious or significant infections by closing the wound over and effectively trapping, if you like, the bacteria within the tissues.

Q That can be the case even if the wound has been inspected and washed the previous day or a couple of days before?
A It can be, yes.
Q Which is why you would always inspect the wound?
A Yes."

289. In cross examination Dr O said that she had expected that Ms DD (consultant dealing with the case) would be called in to inspect the wound. Dr Biesgen suggested to Dr O that he had spoken to Ms DD and that he had explained the procedure to Dr O. Dr O was quite robust in her denials of Dr Biesgen's suggestions and was adamant that she had carried out the procedure on her own. The Tribunal has no reason to disbelieve Dr O's account. The Tribunal notes the list is under Dr Biesgen's name and he was therefore responsible for it. He therefore had a duty to assess the wound before instructing his junior to close the wound.

290. Accordingly, paragraph 15b is found proved.

f. failed to inform Dr O and/or operating theatre staff:

i. **that you were leaving the operating theatre;** Found Proved

ii. of your whereabouts; Found Proved

iii. **how you could be contacted** Found Proved

291. In his witness statement, Dr Biesgen stated: *'I have two mobiles – German and UK mobiles – a bleep, and I would be accessible by tannoy whilst in the hospital assessing patients in the wards or casualty which were both accessible by tannoy and I was in fact contacted by Dr [O] in another case whilst I was out running (see patient L). The notice board in the theatre would always have my mobile and, what is more important, Dr [O] had no need to contact me as I was not expected until 1100.'*

292. Dr O's evidence is that Dr Biesgen left the theatre whilst she was closing the wound: *'It is common practice that had he needed to leave the theatre for some reason to have let me know that (i) he was leaving and (ii) where he was going or how I could contact him should I need his assistance. Neither of these two things happened… I do not know when he left the theatre or where he went to. I just know that he left and did not say where he was going due to the fact that Miss DD came into the theatre looking for him and he was not there.'*

293. According to the expert witness, Dr Biesgen could leave if he thought that Dr O was competent but he should have notified Dr O and the theatre staff that he was leaving, and where he was going to be if they needed to contact him. The Tribunal accepts the opinion of the expert.

294. Accordingly, paragraph 15ci, 15cii and 15ciii are found proved.

Patient P

295. The GMC Expert witness, Mr R, provides a summary of the case of Patient P. Patient P was admitted as an emergency on 20 November 2012. He had sustained injuries to his left hand including the index, middle, ring and little fingers. He was prescribed antibiotics and analgesia and the hand was dressed and elevated. He was consented for surgery on the day of admission by another doctor. The operation was performed by Dr O and Dr Biesgen on 23 November 2012. The wounds were debrided, the open distal interphalangeal joints of the middle, ring and little fingers were fixed with K wires. Fracture of the middle phalanx was fixed with cross K wires. Dr O performed the surgery with Dr Biesgen supervising.

Patient P

33. On 23 November 2012, you supervised Dr O who was operating on Patient P, and you:

c. were not familiar with the:

iii. **steps required in the surgical procedure;** Found Not Proved

iv. surgical equipment needed for the surgical procedure; Found Not Proved

296. In his witness statement, Dr Biesgen stated: '*This is absolute nonsense as I have performed such procedures hundreds of times before without any complication and, in this case, it was I who carried out the procedure on two of the fingers allowing Dr O to do the third one, with my help. Patient L (x-rays on pp C5/144-150) was one where I had used K wires previously and Mr R has confirmed that the x-rays (on pages C5/615 & 616) in both cases (L and P) confirm the correct application of k-wires.'*

297. In her oral evidence, Dr O stated: *"It is very difficult for me to say because at the level I was, as a CT2, I was a senior house officer and, as I have already mentioned, I had not previously performed any operations with a k-wire fixation. Subsequently, in my training, I have. I appreciate that sometimes there are difficulties with the equipment and the drivers that they use for the k-wires, as well as the actual equipment for fixing fractures, can vary between hospital trusts and even with a trust itself. If he was having difficulty with the equipment I cannot be sure that that was because of an unfamiliarity, a lack of expertise or whether it was just a genuine equipment problem on that day. I cannot comment on that.'*

298. Dr O also stated: *'At the time, I remember wondering and feeling concerned as to whether or not Dr Biesgen had the relevant expertise… Throughout the procedure… there was no discussion in relation to surgical options or surgical techniques…'*

299. The Tribunal found that Dr O did not like the way Dr Biesgen had supervised her during the procedure because he asked her what she thought should be done rather than telling her. In her statement she accepted that there were different ways of teaching and that *'sometimes you are required to come up with your own answers'*. She felt unsupported by his approach. However, Dr Biesgen was obviously happy with the answers she gave and the operation was successful. The Tribunal finds there is no evidence that Dr Biesgen was unfamiliar with the steps required in this surgical procedure.

300. Dr O also had the impression that Dr Biesgen was unfamiliar with the k-wire driver at the time it was being used. However, she acknowledged in her witness statement: *'However, occasionally there are problems with the machine and with the wires. As I was inexperienced back then, I couldn't say whether Dr Biesgen's difficulties were due to problems with the drill machine or his unfamiliarity or inexperience with using such equipment.'*

301. As a result of her statement, the Tribunal is unable to conclude that Dr Biesgen was unfamiliar with the surgical equipment.

302. Accordingly, paragraph 16ai and 16aii is found not proved.

d. failed to:

iii. adequately communicate with Dr O who was undertaking the surgical procedure for the first time;
Found Not Proved

iv. **give adequate and/or appropriate guidance to Dr O**
Found Not Proved

303. In his witness statement, Dr Biesgen stated: *'the operation and fixation has been correct; Dr O had never carried out such a procedure before and in fact had not even seen one before so she could not possibly have carried out such a procedure on her own; without supervision, Dr O could not possibly have achieved the result that she did on the third finger. The fact is that I had to hold her hand whilst she did the k-wires on the third finger. I have to concede though that I was [XXX] and left after this operation, handing over to Dr GG, as is indicated in correspondence with Mr T at C2/20.'*

304. Dr O in her witness statement said: *'I appreciate that there are many ways of teaching, and sometimes people do require a challenge, and sometimes you are required to come up with your own answers. However, in this particular circumstance I felt like I was being given no guidance at all. I also felt like Dr Biesgen didn't know what he was doing. There was no discussion regarding treatment options or treatment strategies and I felt very uncertain at the conclusion of the surgery that the patient had been provided with the right operation at the right time and that the surgery had been done in the correct manner. I have never felt like this after a case as I did on this day.'*

305. In her witness statement, Dr O stated: *'I can recall throughout the entire operation that whenever I made a suggestion, Dr Biesgen just agreed with me and encouraged me to proceed with whatever suggestion I made.'*

306. The expert said in his report that a failure to communicate with a junior surgeon in these circumstances would fall below the standard expected, as would a failure to support her or guide her adequately during the operation.

307. The Tribunal observed that the operation was successful even though it was the first time that Dr O had undertaken a k-wire fixation. It accepts the evidence that it would have been impossible to achieve these results without adequate and appropriate guidance. Whilst Dr O did not appreciate Dr Biesgen's approach, the operation was a success and Dr Biesgen continued to supervise until the operation was completed.

308. Accordingly, paragraph 16bi and 16bii are found not proved.

<u>Patient Q</u>

309. The GMC Expert witness, Mr R, provides a summary of the case of Patient Q. Patient Q was admitted by another Registrar, Mr GG, on 23 November 2012 having sustained a crush injury to the hand. According to the statement of Dr O, Mr GG came to the Emergency Plastic Surgery list to inform the operating team that the patient required an urgent carpal tunnel decompression and fasciotomies to release a compartment syndrome. Dr Biesgen who was rostered to cover the list, left the operating theatre whilst the patient was in the anaesthetic room. Dr Biesgen did not inform any of his colleagues or the theatre staff and simply left the theatre. The

operation therefore had to be performed by Mr GG who had other clinical duties to perform.

Patient Q

34. On 23 November 2012, despite being rostered to do the Emergency Plastic Surgery list, you:

c. **left the operating theatre whilst Patient Q, who required an urgent procedure, was in the anaesthetic room;** Found Proved

310. In his closing submission, Dr Biesgen states: *'Page 20 at the bottom covers the fact that Dr Biesgen had "[XXX]" and Mr T would recommend two clear days before returning to patient contact and it goes on to say that Dr Biesgen was responsible for the list in the morning and [XXX] (on 23/11/12). The note is dated 28/11/12 and is suggesting a meeting on Monday (P21), which would be 3/12/12. P22 is dated 3/12/12 and confirms that Dr Biesgen was not there and that it was hoped that he had [XXX].'*

311. In her witness statement Dr O describes how at the conclusion of the hand trauma case: '*Dr Biesgen exited the operating theatre and Dr GG had to perform the last theatre case… Dr Biesgen never said where he was going, he just left the theatre. The patient was in the anaesthetic room at that time so Dr GG scrubbed and performed the surgery on the last patient. I can recall him being annoyed.'*

312. This allegation is based entirely on Dr O's evidence. She had found it odd that Dr Biesgen had left theatre before the end of the list and sent an email on 26 November 2012 to report this. She was not aware that Dr Biesgen was XXX and that he had handed over to Mr GG. There is some evidence to support the assertion that Dr Biesgen was XXX. In the email sent to Dr Biesgen by Mr T on 28 November, Mr T says *'I am sorry to hear you have had [XXX].'* The Tribunal considered the wording of the charge and finds that, as a matter of fact, Dr Biesgen did leave the operating theatre whilst the patient was in the anaesthetic room. However, there is no criticism attached to this finding as Dr Biesgen told the Tribunal that he had XXX and there is some evidence to support this assertion.

313. Accordingly, paragraph 17a is found proved.

d. failed to:

iv. communicate with colleagues to ensure that there was a formal handover; Found Not Proved

v. inform the operating theatre team of your whereabouts; Found Proved

vi. **ensure that there was an adequately experienced and trained surgeon available to complete the list** Found Not Proved

314. In his witness statement, Dr Biesgen stated: *'It is clear from the foregoing that Dr Biesgen was [XXX] and his priority was to ensure that there was a competent surgeon to take over from him. Page 20 indicates that "[XXX]" Dr Biesgen handed over to SPR GG who handled the remaining surgery on the list. Dr Biesgen who, in the preceding paragraph, is being told to stay away for at least two days after recovery, needs to be away from the theatre and, in the circumstances, he has done well to ensure that he has done an adequate handover and Mr T, on page 20 does not take issue with this at all. … In the circumstances, it is submitted that this complaint has no merit and Dr Biesgen acted as responsibly as he could.'*

315. The opinion of the expert is that: '*The concerns raised over this patient relate to a lack of communication. Dr Biesgen states he [XXX] and informed [Mr GG] and handed over the care of the patient to him. He does not state whether he informed the theatre staff of the change over.' Mr R added: 'A surgeon would say, "I am sorry, I am unable to continue", for whatever reason, whether it is [XXX] or something else they have to do. "I am unable to continue. I have contacted Mr X. He is going to come and continue the list".'*

316. The Tribunal considered whether Dr Biesgen had a duty to communicate with his colleagues about why he was leaving theatre. It considers that, although it would have been ideal for Dr Biesgen to have communicated with his colleagues first, the priority for him was to ensure there was appropriate cover by a fellow surgeon, which he did by handing over to Mr GG.

317. The Tribunal has found: <u>In relation to paragraph 17bi</u> – Dr O who was working with Dr Biesgen during the operating list stated that he did not communicate with colleagues about his departure. The Tribunal accepted Mr R's evidence in re-examination that some communication was necessary. This would by no means constitute a formal handover, merely informing colleagues of Dr Biesgen's intention to leave immediately. Mr R had been informed whilst giving evidence that Dr Biesgen XXX on 23 November 2012. The Tribunal accepted the expert's evidence in re-examination. Therefore the Tribunal found that, given that Dr Biesgen XXX, a formal handover was not required.

318. Accordingly, paragraph 17bi is found not proved.

319. The Tribunal has found: <u>In relation to paragraph 17bii</u> – Dr O gave evidence that Dr Biesgen had not informed the operating team about his whereabouts. The Tribunal accepted this evidence. In re-examination, Mr R said that the surgeon who was performing the operating list was responsible for informing the staff that he was leaving because the theatre team may wish to ask questions. Whilst the Tribunal

does not consider that a formal handover was required in these circumstances, it found that he should have told the theatre team that he was leaving theatre.

320. Accordingly, paragraph 17bii is found proved.

321. The Tribunal has found: In relation to paragraph 17biii – the list was completed by Mr GG. On 28 November Mr T emailed Dr Biesgen and stated: *'I understand that you were responsible for the list [23 November 2012] and [XXX], handing over to GG.'* Mr T did not criticise that decision. Therefore Tribunal found that Mr GG was adequately experienced to complete the list.

322. Accordingly, paragraph 17biii, is found not proved.

Determination: Adjourn and Directions – 16 August 2018

1. There is now clearly insufficient time to conclude the case by the end of today, the last scheduled day. Therefore, the hearing will adjourn part-heard again.

2. Dr Biesgen has indicated in his email of 14 August 2018 at 17:37 (D42) that he requires time to produce the documents he wishes to place before the Tribunal. In the interests of fairness and because the doctor is unrepresented the Tribunal has decided to afford him some time.

3. The Tribunal estimates that a further 5 days will be required to conclude the case. It is essential that the following directions are complied with. The Tribunal has identified the following dates, which have been agreed by all parties:

Monday 15 October – Friday 19 October 2018.

4. The Tribunal makes the following directions:

- Dr Biesgen is to submit to the MPTS all the documentary evidence he wishes to put before the Tribunal by 15 September 2018.
- Parties are to submit written submissions on impairment to the MPTS by 8 October 2018.
- Parties are to notify MPTS of any witnesses they intend to call at the impairment stage by 15 September 2018.
- Witness statements are to be provided for any witnesses that are called. These are to be submitted to MPTS by 15 September 2018.

5. The submissions and any other documents are to be sent to the following 3 email addresses.

XXX
XXX
XXX

6. Please note that Transcripts will NOT be provided as the hearing has progressed beyond the Facts stage.

7. This hearing is now adjourned, to re-convene at 9.30 on Monday 15 October 2018. It will commence in public session to hear submissions on impairment.

8. The parties, in particular Dr Biesgen, may be assisted by the following guidance:

GUIDANCE AT THE IMPAIRMENT STAGE

At the second stage of the hearing, the Tribunal must decide whether the doctor's fitness to practice is impaired on the facts it has found proved. If impairment is found the Tribunal is required to go on to the third stage to consider what sanction, if any, is appropriate. Sanctions go in ascending order of seriousness from taking no action, imposing conditions, imposing a period of suspension and erasure from the register. If impairment is not found the Tribunal may take no action or may issue a warning. The latter remains on the doctor's registration for two years.

The Tribunal must first consider whether, on the facts found proved, there has been deficient professional performance. This simply means performance which falls below the standard expected of a reasonably competent practitioner in the doctor's field of practise. The Tribunal does not apply a gold or text book standard.

If the Tribunal finds there has been deficient professional performance, it goes on to consider whether as a result the doctor's current and future fitness to practice is impaired. That is why it is essential to produce up to date material, in terms of references, testimonials and training. There is no burden or standard of proof. It is a matter of judgement.

When considering impairment the Tribunal must ask itself three questions:

(1) Is the deficiency easily remedied?
(2) Has it been remedied?
(3) Is there a likely risk of repetition?

Steps taken since the events concerned to address them are therefore highly relevant. This could include CPD and proof of further training.

The Tribunal is always concerned with a doctor's insight into the events which are the subject of the case. It is a core factor. This means, does the doctor understand what has gone wrong and the consequences of that? If the Tribunal has found that clinical errors occurred, insight would involve the doctor acknowledging them, taking steps to remedy them and showing that there has been learning from what has occurred. This is often referred to as reflection and is usually expressed in written reflection documents.
Details of training taken since the events, and testimonials from those who can speak of the doctor's current competence and dedication, may be presented. The Tribunal would expect to be informed of the doctor's current practising arrangements and future professional plans. Sometimes character or other witnesses are called to give evidence in person, or by video link or telephone. The doctor can of course give evidence. Any evidence to be presented is of course a matter for the doctor.

Determination on Impairment - 16/10/2018

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved, Dr Biesgen's fitness to practise is currently impaired by reason of his deficient professional performance.

2. In summary, the Tribunal found the following:

Patient A
Between 27 June 2012 and 10 July 2012, Dr Biesgen consulted with Patient A and he failed to arrange an appropriate treatment plan, in that he advised an open reduction of Patient A's fracture and fixation with the application of a plate.

Patient B
On 3 July 2012, Dr Biesgen consulted with Patient B and he failed to arrange an appropriate and/or clinically indicated treatment plan, in that he advised that an external fixator should be applied six weeks following injury and failed to refer Patient B for outpatient hand therapy.

Patient D
On 1 August 2012, Dr Biesgen consulted with Patient D and he failed to adequately assess Patient D, in that he deemed that no further follow up was necessary, but that hand therapy should continue. Dr Biesgen also made an inadequate clinical record, in that he recorded that Patient D had a full range of movement.

Patient F
On 18 July 2012, Dr Biesgen consulted with Patient F and he failed to institute an adequate and/or appropriate treatment plan, to include adequate and appropriate follow up care and hand therapy.

Patient I
On 19 July 2012, Dr Biesgen consulted with Patient I and he failed to: ascertain and record what the functional problem was for Patient I; arrange an X-Ray of the stiff joint to determine the nature of the underlying problem; and to determine an adequate treatment plan.

Patient J
On 3 August 2012, Dr Biesgen operated on Patient J and he failed to: undertake adequate and/or appropriate post-operative checks; arrange an adequate and/or appropriate treatment plan post-operatively; and to make an adequate and/or appropriate referral for post-operative hand therapy.

Patient K
On 3 August 2012, Dr Biesgen operated on Patient K and he failed to adequately reduce and fix Patient K's fracture and failed to determine that the fracture was adequately treated.

Patient L
On 10 October 2012, Dr Biesgen operated on Patient L and he failed to record the details of the circulation in Patient L's thumb at the end of the operative procedure and the status of the circulation in the arteries.

Patient M
On 15 October 2012, Dr Biesgen operated on Patient M and he failed to identify the injury to the main trunk of the median nerve and the injury to the palmar cutaneous branch.

Patient N
On 23 November 2012, Dr Biesgen failed to assess the wound on Patient N's thigh before instructing a junior doctor (Dr O) to close the wound. He also failed to inform Dr O and/or operating theatre staff that he was leaving the operating theatre; of his whereabouts; and how he could be contacted.

Patient Q
On 23 November 2012, despite being rostered to do the Emergency Plastic Surgery list, Dr Biesgen left the operating theatre whilst Patient Q, who required an urgent procedure, was in the anaesthetic room; and he failed to inform the operating theatre team of his whereabouts.

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, and documentary evidence and written submissions sent by Dr Biesgen and those made by Mr Taylor on behalf of the GMC.

Submissions – For The GMC

4. On behalf of the GMC, Mr Taylor submitted that, on the basis of the facts found proved, Dr Biesgen's fitness to practise is impaired. He submitted that Dr Biesgen's failings are serious and significant departures from Good Medical Practice relating to 11 different patients over a short period of time. Mr Taylor referred the Tribunal to Good Medical Practice (2006) and to the various paragraphs which he submitted have been breached by Dr Biesgen, namely paragraphs 2(a) [Patients D, I, J, M and N]; 2(b) [Patients A, B, F, I, J, K and M]; 2(c) [Patients B, I and J]; 3(c) [Patients A, B, F, I, K and M]; 3(f) [Patients D, I and L]; 3(h) [Patient N]; 41(b) [Patients N and Q]; and 41(c) [Patients N and Q].

5. Mr Taylor reminded the Tribunal of the conclusions of the expert witness in this case who found that Dr Biesgen's performance fell below the standard expected of a reasonably competent Consultant in Plastic Surgery (Leeds)/Senior Registrar in Plastic Surgery (Cambridge) in relation to all 11 patients. In relation to Patient J the expert witness found that the standard fell seriously below the requisite standard.

6. Mr Taylor referred the Tribunal to relevant case law, namely Calhaem v GMC (2007) EWHC 2606 (Admin), in which Jackson J stated:

> (at paragraph 26): *'The phrase 'deficient professional performance' does not mean any instance of sub-standard work; it connotes a level of professional performance which indicates that the doctor's fitness to practise is impaired.'*
>
> (at paragraph 39): '(3)"*Deficient professional performance" within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work. (4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance". (5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct".* '

7. Mr Taylor submitted that the findings of the Tribunal in relation to the 11 patients connote a standard of professional performance which is unacceptably low, as confirmed by the GMC expert. He further submitted that the standard of the doctor's work has been demonstrated by reference to a fair sample. Dr Biesgen's failings in relation to Patients A, B, D, F, I, J and K occurred (in Leeds) over a period of less than six weeks; He was only in Leeds for three months, and for the latter part of that period he was restricted to an observer/supervised role. Mr Taylor submitted that similarly, Dr Biesgen's failings in relation to Patients L, M, N and Q occurred (in Cambridge) over a period of six weeks. He had been in Cambridge for a matter of weeks earlier in the year, and he remained in Cambridge for a further six weeks only, during which time he was withdrawn from the on call rota as well as from outpatient local anaesthetic and trauma lists.

8. Mr Taylor submitted that accordingly, the Tribunal should find that the matters found proved amount to deficient professional performance.

9. As to impairment – Mr Taylor referred the Tribunal to relevant case law, including:

- Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Paula Grant (2011) EWHC 927 (Admin);

- Cohen v GMC (2008) EWHC 581 (Admin); and

- R (on the Application of Harry) v General Medical Council (2006) EWHC 3050 (Admin).

10. As to remediation – Mr Taylor submitted that although deficiencies in professional performance like clinical errors or incompetence amounting to misconduct are potentially remediable, there is no evidence of remediation in this case. He further submitted that, on the contrary, Dr Biesgen does not accept any criticism as, in his evidence, he asserted that he would treat the patients in exactly the same way today. Mr Taylor submitted that in the absence of any evidence of remediation, Dr Biesgen continues to present a risk to members of the public; therefore the Tribunal cannot be satisfied that it is highly unlikely that his deficient professional performance would be repeated, and so his fitness to practise should be found to be impaired. In addition, he submitted that the need to uphold proper professional standards and public confidence in the profession would be undermined were a finding of impairment not to be made.

11. As to Insight – Mr Taylor referred the Tribunal to paragraph 52 of the Sanctions Guidance: *'A doctor is likely to lack insight if they: a. refuse to apologise or accept their mistakes; b. promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing; c. do not demonstrate the timely development of insight; d. fail to tell the truth during the hearing.'*

12. Mr Taylor submitted that Dr Biesgen does not acknowledge any failings on his part. He referred to the Tribunal's comments in its determination on the facts, namely that he appeared to be full of his own self-importance and took every opportunity to tell the GMC witnesses how successful and renowned he was as a surgeon. He also denied having been limited in his roles at Leeds and Cambridge despite documentary evidence of this. He was vague about the dates he was present at Leeds. He was evasive at times and would launch into a lecture instead of answering questions posed to him. He made the statement that he was his own expert … he persisted in asserting this and also derided Mr R as being a "non-expert".

13. Mr Taylor submitted that Dr Biesgen's response to the findings made against him illustrates that he does not accept those findings and on the contrary he continues to be contemptuous of the Tribunal and the regulatory process.

14. Mr Taylor submitted that, although Dr Biesgen asserts that he is the head of the department of plastic surgery in a clinic in Switzerland, there is no objective evidence of this and that the materials he has submitted go back several years and are of no relevance to the Tribunal's findings. He submitted that in such circumstances where the Tribunal has before it no evidence of Dr Biesgen's recent performance in a clinical setting, his failure clearly and unambiguously to acknowledge his failings is a matter of serious concern. He submitted that in circumstances where Dr Biesgen has no insight whatsoever into his deficiencies, the Tribunal is driven to conclude that his fitness to practise is impaired.

15. In conclusion, Mr Taylor referred the Tribunal to paragraph 76 of Grant, in which Cox J, referring to paragraph 25.67 of the Fifth Shipman report, posed the following question:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession…'*

16. Mr Taylor submitted that Dr Biesgen has, through his deficient professional performance, put patients at unwarranted risk of harm and has thereby breached one of the fundamental tenets of the profession. He submitted that Dr Biesgen has brought the profession into disrepute and that he is consumed by his own self-perceived greatness; has no insight into his deficiencies, has not remediated them, and so he continues to pose a risk to patients. Mr Taylor added that Dr Biesgen's attitude towards the regulator and the regulatory proceedings has been deplorable and that in all the circumstances the Tribunal should find that Dr Biesgen's fitness to practise is impaired by reason of his deficient professional performance.

Submissions – For The Practitioner

17. Dr Biesgen in his written submissions stated that he was '*extremely grateful for the adjournment which has enabled me to get certifications from the medical authorities in whose jurisdiction I practice that there are no known complaints of my medical practice and testimonials and CPD material …'*

Testimonials and Proof of further training and CPD

18. Dr Biesgen then makes references to the testimonials which he had attached to his submissions and to his proof of further training and CPD. This included certificates of conferences and training courses attended. Dr Biesgen also stated that he is compliant with the CPD requirements of the German authorities.

Information as to his current medical practice and employment

19. In his submissions, dated 11 October 2018, Dr Biesgen stated: *'I am the head of plastic surgery at a teaching hospital in Germany and also practice at plastic surgery clinics in Switzerland. The panel will be aware from published material included in the bundles that I have carried out two re-attachments of severed hands in operations lasting 13/14 hours, having previously assisted in several such operations. I practice at the highest level of surgery in my field and have not had any complaints of any sort other than those by one solitary consultant in Leeds with whom I never worked and, unlike the seven-week stretch working with Professor BB, who had no complaints of any sort, I worked for potentially three weeks in the team of which the solitary consultant was a part. I append herewith as exhibit 9 letters from both Switzerland and Germany, being the jurisdictions within which I practice, confirming that they are not aware of ANY complaints against me so that there have been no complaints since 2012 which would confirm that whatever view the panel may have of my practice in 2012 whether by virtue of language problems or otherwise there has been no cause for concern in the six years since.'*

Reflection on what occurred in 2012 and what insight has been gained

20. Dr Biesgen makes reference to his response already given to the facts found proved, namely that `*the factual matrix which, if properly reflected, would indicate that the decision on facts is not safe on just about anything. I am afraid whilst I appreciate that at this stage the panel may well wish to offer sympathy if I expressed contrition I would have to be a hypocrite if I said otherwise, having already indicated my stance which I cannot deviate from as that would be dishonest.'*

Comments on Impairment

21. Dr Biesgen gives the following responses to the three questions posed:

> *'Is the deficiency easily remedied? Given that there are no complaints for the past six years of practice at the highest levels in my field surely the panel can conclude that the "deficiency", if any, has already been remedied;*
>
> *Has it (the deficiency) been remedied? Given the response to 11.1 above surely the deficiency, if any, has been remedied as there is no evidence of repetition.*
>
> *Is there a likely risk of repetition? If there is no "repetition" in over six years since the last complaint arose one would hope that there has been no repetition and therefore one would expect the clear inference to be that there is no risk of repetition.'*

22. Dr Biesgen then addresses the matter of sanction, which is not relevant at this stage of the proceedings.

ADJOURNMENT – 15 October 2018

23. Following the receipt of the written submissions, the Tribunal determined to email Dr Biesgen a copy of the GMC written submissions. Dr Biesgen was given until 2pm to respond. He did respond at 13.48 to state that he was at work and that he would comment 'later in the day or overnight'. The Tribunal received advice from the Legal Assessor and the Tribunal determined to allow Dr Biesgen until 09:30 on Tuesday 16 October 2018.

Further Response from Dr Biesgen

24. The Tribunal has taken account of the response sent by Dr Biesgen on 15 October 2018 at 22:41, in which he makes comments on Mr Taylor's submissions on impairment. The Tribunal notes that a number of the comments relate to sanction and are therefore not relevant to this impairment stage of the proceedings. The comments that relate to impairment have been noted, namely: '*If NOTHING has happened over six years surely that is adequate EVIDENCE of the fact that there is no remediation needed.'*

LEGAL ASSESSOR'S ADVICE

25. The Legal Assessor advised the Tribunal that although this is a performance case, not one of alleged misconduct, there is no performance assessment; the Tribunal will have to consider the parts of the allegation it has found proved and consider whether it finds the following test is, or is not, met:

> 'The phrase "deficient professional performance" does not mean any instance of sub-standard work; it connotes a level of professional performance which indicates that the doctor's fitness to practise is impaired. - Calhaem v GMC [2007] EWHC 2606 paragraph 26'

26. The Legal Assessor advised the Tribunal to have due regard to the relevant parts of Good Medical Practice 2006 to which it has been referred. He further advised that the standard it should apply is that of a reasonably competent doctor in Dr Biesgen's field of practice – *'It is not a gold or text book standard.'*

27. As to whether the Tribunal had seen a fair sample of Dr Biesgen's work, the Legal Assessor advised that the cases that this Tribunal has been concerned with arose over two relatively short periods in two hospitals in 2012. He advised that whether it is a fair sample is a matter for the Tribunal. He advised that there is no statistical element in the test and clearly it would be normal in performance cases for the cases to be limited in number compared to the number of patients which a doctor may have treated in a career.

28. As to impairment, the Legal Assessor advised the Tribunal that Dr Biesgen has now provided some testimonials and evidence of courses attended and that it is a matter for

it to decide if they meet the deficiencies the Tribunal has found and what weight to place upon them. He advised that the Tribunal should consider whether the public interest in maintaining confidence in the profession and its regulator outweighs the interests of the doctor, whatever mitigation may exist. The Legal Assessor advised the Tribunal to consider what a member of the public would think if impairment were not found following its findings of fact. He advised that it should consider that issue having in mind the principle of proportionality.

The Tribunal's Approach

29. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

30. The Tribunal has given careful consideration to all the evidence adduced during the course of these proceedings, both oral and documentary. It has also taken account of submissions made by Mr Taylor, Counsel, on behalf of the GMC, and those of Dr Biesgen.

31. In deciding whether Dr Biesgen's fitness to practise is impaired, the Tribunal has exercised its own judgement. It has borne in mind the statutory overarching objective which is to protect the public. This includes: to protect and promote the health, safety and wellbeing of the public; to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards of conduct for members of the profession. The Tribunal would not give excessive weight to any single limb.

32. The Tribunal reminded itself that the purpose of these proceedings is not to punish a doctor for past wrongdoing but to maintain proper standards in the profession and to protect the public. The Tribunal must look forward, not back, but in order to determine whether a doctor is currently fit to practise without restriction it must take into account the way in which a doctor has acted, or failed to act, in the past.

33. In considering this matter the Tribunal reminded itself that it must follow a two-step process. It must first consider whether the facts admitted and found proved amount to deficient professional performance and, if so, it must then decide whether as a result Dr Biesgen's fitness to practise is impaired. The Tribunal also considered if there was any evidence provided regarding insight and remediation, and the likelihood of repetition.

The Tribunal's Decision

Deficient Professional Performance

34. The Tribunal first considered whether Dr Biesgen's actions amount to deficient professional performance.

35. In the absence of a formal GMC performance assessment, the Tribunal was concerned whether it had been presented with a fair and broad enough sample of Dr Biesgen's work. The Tribunal has considered the legal advice and the examples set out in case law.

36. The Tribunal acknowledges that when Dr Biesgen arrived at Leeds, he had little induction and there is evidence of him being "thrown in at the deep end"; having arrived in the UK only a few months earlier as a senior fellow, he was within 24 hours of starting at Leeds scheduled to work in clinics on his own. There is also no evidence that any of the consultants told Dr Biesgen about any concerns they had about his abilities.

37. Having acknowledged this, the Tribunal notes that Dr Biesgen's failings were matters with which a trained plastic surgeon should have been competent to deal. The Tribunal further notes that Dr Biesgen's main speciality is plastic surgery and, as part of his duties as a plastic surgeon, he worked in the field of trauma hand surgery at Leeds and Cambridge. Almost all the cases that this Tribunal considered at both hospitals and where failings were found related to hand surgery.

38. In Dr Biesgen's short period of time at Leeds and Cambridge there were a number of errors and omissions relating to his decision making, surgical skills and communication. The Tribunal considers that, notwithstanding the lack of induction at Leeds, as a plastic surgeon Dr Biesgen should have known how to perform the tasks for which he has been criticised. Furthermore, if he did not know he should have sought advice.

39. Having found a number of failings in several cases over a short period of time, the Tribunal has found Dr Biesgen's actions amount to deficient professional performance.

Impairment In Relation To Deficient Professional Performance

40. The issue of impairment is one for the Tribunal to determine exercising its own judgement. The Tribunal has taken into account the public interest, which includes the need to protect patients and the public, to maintain public confidence in the profession, and to declare and uphold proper standards of conduct and behaviour. In considering the matter of impairment, the Tribunal has noted the case of Cohen v GMC [2008] EWHC 581 (Admin) in which Silber J stated, at paragraph 65:

> *"…It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."*

41. The Tribunal first considered whether there has been any remediation and whether Dr Biesgen has shown any insight into the findings made against him.

42. The Tribunal has taken account of the certificate from Switzerland dated 30 August 2018, which attests to Dr Biesgen's good standing in specialist plastic, reconstructive and aesthetic surgery. The certificate from Germany dated 1 October 2018 certifies that Dr Biesgen is entitled to practise medicine without restrictions in the Federal Republic of Germany. It also confirms that *'there is currently no indication of any legal or professional measures'*.

43. Dr Biesgen has produced evidence of CPD and the Tribunal has no reason to doubt that he is up to date. There is evidence of his attendance at a conference on hand surgery in 2013. The Tribunal is of the view that a limited number of the certificates are relevant to hand surgery but some of the documents are in German and therefore it is unable to say what they refer to. Some of the courses were to do with surgery other than that of hands.

44. As to insight, the Tribunal has noted the comments made by Dr Biesgen in his written submission and email to the Tribunal. At no point has he accepted the allegations or the findings made against him. He has maintained that he cannot accept the findings of the Tribunal in his most recent email sent on 15 October 2018. The Tribunal has also noted his persistent assertion that he was not restricted to an observer/supervisor role at Leeds. This is despite the clear evidence presented to the Tribunal that he was.

45. The Tribunal has concluded that the failings found were remediable. However, as Dr Biesgen does not accept these failings, he cannot have remedied those faults. The Tribunal has concluded that Dr Biesgen has no insight. The Tribunal notes that he appears to be working effectively in Germany; however, he has presented no current independent evidence of this. None of the testimonials mention his referral to the GMC and the writers are somewhat vague about the nature of their relationship with him. Some testimonials are undated. Therefore, whilst the testimonials are positive, the writers' apparent lack of knowledge as to why they were asked to write the testimonials lessens their value.

46. The Tribunal has considered Dame Janet Smith's criteria for impairment set out in her fifth Shipman report and cited in CHRE v NMC and Grant [2011] EWHC 927 (Admin). It has found that Dr Biesgen:

a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm. Whilst, as Dr Biesgen has pointed out, no patient died, the outcomes for a number of patients were not optimal. Given Dr Biesgen's lack of insight and his assertion that he would act in exactly the same way in the future, the Tribunal concluded that there was a continuing risk of harm to patients.

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute. The medical profession's reputation is not enhanced by examples of poor practice. Given Dr Biesgen's lack of insight the Tribunal concluded that there was a real risk of repetition.

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession. The Tribunal considers that the duties of a doctor listed on the inside front cover of GMP 2006 are fundamental tenets. These include that a doctor must provide a good standard of practice and care. In this case Dr Biesgen did not provide a good standard of practice and care. Given his lack of insight there must be a risk of repetition.

47. The Tribunal has reminded itself of the overarching objective and whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made. It has concluded that public confidence would be undermined; therefore the Tribunal has found that Dr Biesgen's fitness to practise is impaired by reason of his deficient professional performance pursuant to Section 35C(2)(b) of the Medical Act 1983, as amended.

Determination on Sanction - 18/10/2018

1. Having determined that Dr Biesgen's fitness to practise is impaired by reason of his deficient professional performance, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. This included the testimonials and evidence of CPD sent by Dr Biesgen.

3. The Tribunal has also taken account of the emails sent by Dr Biesgen and his comments that related to sanction.

Submissions
On behalf of the GMC

4. Mr Taylor commenced his submissions by referring the Tribunal to the Sanctions Guidance (SG) (July 2016) and to a number of paragraphs contained therein.
He submitted that there has been "very little evidence" in terms of remediation and from what has been adduced "very little weight" can be attached to it. As to the testimonials submitted, Mr Taylor referred the Tribunal to paragraph 35 of the SG which coincide with the comments already made by the Tribunal in its impairment

determination, namely that some of them are undated and none make any reference to these proceedings.

5. Mr Taylor submitted that there has been no remediation in this case as Dr Biesgen does not accept that he has done anything wrong. He submitted that, throughout these proceedings, up to and including in his most recent communication Dr Biesgen has showed a total absence of insight. He added that he is "very far away from anything resembling an apology or any expression of remorse". Mr Taylor submitted that as there has been no acceptance of any wrongdoing, there has, as a consequence, been an absence of remediation, remorse and insight.

6. As to the sanctions available to the Tribunal, Mr Taylor submitted that taking no action would be wholly inadequate, taking into account the circumstances of the case. As to conditions, Mr Taylor submitted that in this case, Dr Biesgen has shown no insight whatsoever and, given his attitude, the Tribunal could not be satisfied that he would comply and would respond positively to conditions.

7. Mr Taylor then referred the Tribunal to the paragraphs of the SG that deal with suspension. He reminded the Tribunal of its finding that, due to Dr Biesgen's lack of insight and his persistent insistence that he has done nothing wrong, there was a real risk of Dr Biesgen repeating his actions. Mr Taylor submitted that Dr Biesgen has demonstrated contempt for the regulatory proceedings and does not possess the right attitude for successful remediation; on the contrary he still asserts that he would act in exactly the same way in the future. Mr Taylor submitted, therefore, that suspension is not appropriate in this case.

8. Mr Taylor referred the Tribunal to the criteria listed at paragraph 103 and submitted that points b, c and j are applicable in Dr Biesgen's case. Mr Taylor also referred the Tribunal to paragraph 124, which states:

> *'A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.'*

9. Mr Taylor concluded by submitting that in this case the Tribunal has found serious failings and deficiencies in 11 cases, which occurred over a short period of time. Furthermore, there was evidence of patient harm. He submitted that the appropriate sanction, given all of the above, is erasure.

On behalf of the Practitioner

10. In his written submission on impairment, Dr Biesgen addressed the matter of sanction and stated:

'I sincerely hope that the Panel will see that nothing I have done has resulted in the death of any patient or any patient being maimed or suffering from the ill effects of my treatment. …

… given the fact that in the period of six years since 2012 there have been no complaints recorded whatsoever I would humbly submit that the sanction the panel should consider should be to take no action or, at worst, to allow the complaints to remain on file and if there is any further repetition or serious complaint to then consider what sanctions are necessary as, after six years (the statutory period of limitation), with no complaints, surely there is no need for any sanction.'

I would further submit that, as I have repeatedly stated in voluminous correspondence with the GMC and also in my closing submissions and witness statement filed herein, I have volunteered/repeatedly requested cancellation of my GMC registration so that the panel should have no worries at all that any such occurrence could ever happen again in its jurisdiction, which is within the UK.'

11. In his further email sent on 15 October 2018 at 22:41, Dr Biesgen stated:

'If there has been no problem in the last six years – as confirmed by the competent authorities - surely this is enough evidence to show that there is no need for sanctions …The GMC is totally losing sight of the fact that Dr Biesgen has been practicing at the highest level in his field with NO COMPLAINTS WHATSOEVER FOR OVER SIX YEARS and that must surely be conclusive to indicate that other than punishment for punishment's sake there is NO PERCEIVED RISK TO PATIENTS and the only "sanction" is to take no further action.'

12. Dr Biesgen was emailed the Tribunal's determination on impairment and he was asked if he wished to make any further submissions on the issue of sanction. Dr Biesgen responded on 17 October 2018 at 07:07 by annotating his comments at numerous paragraphs of the Impairment determination. However these comments were not relevant to the matter of sanction and therefore the Tribunal has disregarded them. Dr Biesgen, did make the following additional comment in his email which is of relevance. He stated:

'Whilst I have commented on impairment as there are aspects which are factually incorrect such as an allegation that restrictions had been placed on my work at Leeds based entirely on unsupported hearsay evidence the tribunal has noted that I have made comments on sanctions and would repeat:
If (1) there is no evidence of wrongdoing in over six years; and indeed (2) there is clear and positive confirmation from both Switzerland and Germany that there is no recorded evidence of impairment or non-remediation: surely the only appropriate and proportionate sanction is that of taking no further action.'

The Tribunal's Determination on Sanction

13. The decision as to the appropriate sanction, if any, is a matter for this Tribunal exercising its own judgment. In reaching its decision, the Tribunal has taken account of the SG and the statutory over-arching objective. The Tribunal recognises that the purpose of a sanction is not to be punitive, although it may have a punitive effect.

14. Throughout its deliberations the Tribunal has applied the principle of proportionality, balancing Dr Biesgen's interests with the public interest. It reminded itself that it should only impose the minimum sanction necessary to achieve the over-arching objective. In deciding what sanction, if any, to impose the Tribunal considered each of the sanctions available, starting with the least restrictive. It also considered and balanced the mitigating and aggravating factors in this case.

Aggravating and mitigating factors

Mitigating factors

15. The Tribunal has taken account of the following:

- At paragraph 36 of its determination on impairment, the Tribunal acknowledged the situation that Dr Biesgen faced at Leeds, namely that Dr Biesgen had only been in the UK for 3 months when he took up his locum post at Leeds, where he appears to have had inadequate induction and where he was "thrown in at the deep end";

- Positive testimonials have been provided; however, as noted in the impairment determination some of them pre-date these proceedings, some are undated. None of them mention knowledge of these proceedings and they are therefore of limited value;

- There is evidence of CPD which included attendance at conferences on hand surgery;

- Certificates of Good Standing from Switzerland and Germany;

- The lapse of time since the incidents (now six years ago); and

- Dr Biesgen's evidence that he has practised effectively for the past 6 years with no complaints raised.

Aggravating factors

16. The Tribunal has taken account of the following:

- The failings took place at two different clinical settings at Leeds and Cambridge hospitals;

- There has been a complete lack of insight – even after 6 years there has been no recognition of any wrongdoing and no acceptance of any of the errors made. Dr Biesgen has therefore not reflected on his failings; on the contrary, he has asserted that he would act in exactly the same way now;

- Dr Biesgen has made no effort or attempt to remediate his deficient professional performance;

- Dr Biesgen has not expressed any remorse for his deficient professional performance;

- The testimonials adduced have not been verified (ie, the authors do not state that they are aware of the fitness to practise proceedings and of the facts found proved against Dr Biesgen). In this regard the Tribunal has taken account of the guidance at paragraphs 34-36 of the SG; and

- The Tribunal considered that Dr Biesgen's deficient professional performance in 11 cases over a short period of time also constituted an aggravating factor.

17. Dr Biesgen's actions in 2012 compromised patient safety. Given Dr Biesgen's lack of insight and remediation, the Tribunal concludes that there is a continuing risk to patients and a risk of Dr Biesgen repeating his failings.

18. The Tribunal then considered the sanctions starting from the least restrictive.

No action

19. The Tribunal first considered whether to conclude Dr Biesgen's case by taking no action with regard to his registration. Dr Biesgen broke a fundamental tenet of his profession through his deficient professional performance. The Tribunal has seen no exceptional circumstances that would justify taking no action in this case.

Conditions

20. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Biesgen's registration. Any conditions imposed would need to be appropriate, proportionate, workable and measurable.

21. The Tribunal was of the view that it could formulate suitable conditions to address Dr Biesgen's deficient professional performance. However, taking into account Dr Biesgen's lack of acceptance of any wrongdoing and his lack of insight into his failings, the Tribunal is not satisfied that he would respond positively to conditions. His lack of acceptance of the Tribunal's findings suggests that he would not comply with conditions and that they would be unworkable. The Tribunal also

notes that Dr Biesgen is working in Germany and Switzerland and says he has no intention of returning to work in the UK. It was of the view that any conditions it imposed at this stage would serve no useful purpose. Further, the Tribunal determined that a period of conditional registration would not adequately protect public confidence in the profession nor uphold proper standards of conduct for members of the profession.

Suspension

22. The Tribunal moved on to consider whether it would be sufficient to impose a period of suspension on Dr Biesgen's registration. The Tribunal has borne in mind the SG in relation to suspension, including paragraphs 85 and 88 in which it states:

> ***85*** *Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> ***88*** *Suspension is also likely to be appropriate in a case of deficient performance or lack of knowledge of English in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.*

23. The Tribunal considered whether or not any of the criteria indicating suspension may be applicable, as set out in paragraph 91 of the SG. It concluded that sub-paragraphs (a), (b), (e), (f) and (g) were potentially relevant, but the Tribunal found that Dr Biesgen's total lack of insight meant that none of these sub-paragraphs could be engaged.

24. The Tribunal had regard to the aggravating features in this case, in particular Dr Biesgen's complete lack of insight. It has already determined that, as a result, there is a real risk of repetition. The Tribunal therefore concluded that to suspend Dr Biesgen's registration would not reflect the seriousness of his deficient professional performance and more importantly his failure to acknowledge it.

Erasure

25. The Tribunal had regard to the factors set out in paragraph 103 of the SG, the presence of any of which is likely to indicate that an order of erasure may be appropriate. The Tribunal found the following present in Dr Biesgen's case:

> `***b.*** *A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.*

> ***c.*** *Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients ….*
>
> ***j.*** *Persistent lack of insight into the seriousness of their actions or the consequences.'*

26. Having considered the aggravating and mitigating features and the need to impose a proportionate sanction which is consistent with the overarching objective, the Tribunal was satisfied that Dr Biesgen's deficient professional performance was serious and his insight into it so lacking, as to be fundamentally incompatible with his continued registration.

27. The Tribunal has determined that erasure from the medical register is the appropriate and proportionate outcome in this case to mark the seriousness with which it views Dr Biesgen's lack of insight. It is the only sanction that will fulfil the overarching objective of protection of the public, maintaining public confidence in the profession and promoting and maintaining proper professional standards and conduct for members of that profession, notwithstanding that it may have a punitive effect upon Dr Biesgen.

28. Accordingly, the Tribunal has determined that Dr Biesgen's name should be erased from the medical register.

Determination on Immediate Order - 18/10/2018

1. Having determined that Dr Biesgen's name should be erased from the medical register, the Tribunal considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be the subject of an immediate order.

Submissions Of Counsel

2. Mr Taylor, on behalf of the GMC invited the Tribunal to make an immediate order of suspension and referred the Tribunal to its powers to do so. He drew the Tribunal's attention to the relevant paragraphs contained in Sanctions Guidance (SG) (July 2016) and submitted that Dr Biesgen's registration should be subject to an immediate order. He submitted that such an order was appropriate in the circumstances of this case.

The Tribunal's Determination on Immediate Order

3. In reaching its decision as to whether or not to impose an immediate order, the Tribunal had regard to paragraphs 166 and 167 of the SG, which state:

> *'The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. …'* **166**

> *''An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care …, or where immediate action must be taken to protect public confidence in the medical profession..'* **167**

4. The Tribunal had found in its determinations on Impairment and Sanction that Dr Biesgen's deficient professional performance was contrary to all three limbs of the statutory overarching objective and breached the fundamental tenets of the medical profession.

5. When considering Dr Biesgen's interests, the Tribunal has noted that although Dr Biesgen is not currently working in the UK, he could, if he chose to return and if there were to be an appeal, an immediate order would prevent him from working pending the appeal.

6. The Tribunal has determined that satisfying the overarching objective in this case requires it to put patient safety and the public interest before that of Dr Biesgen's own interests given the serious findings made, namely his deficient professional performance. In addition, the Tribunal had found that Dr Biesgen lacks any insight; therefore it is not satisfied that there is no risk of repetition. The Tribunal considered that, in all the circumstances, it would be inappropriate to risk his return to unrestricted practice during the period until the substantive order for erasure took effect.

7. The Tribunal concluded that it is necessary to protect members of the public and otherwise the public interest to impose an immediate order. This means that Dr Biesgen's registration will be immediately suspended when notice of this decision is deemed to have been served. The substantive direction for erasure, as already announced, will take effect 28 days from when written notice of this determination has been served upon Dr Biesgen, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

8. The interim order currently imposed on Dr Biesgen's registration will be revoked when the immediate order takes effect.

9. That concludes this case.

Confirmed
Date 18 October 2018 Mrs Michéle Clare, Chair