PUBLIC RECORD

Dates: 07/04/2025 – 15/04/2025; 03/07/2025 - 04/07/2025

Doctor:	Dr Elroy WELEDJI
GMC reference number:	4394196
Primary medical qualification:	MB BCh 1992 National University of Ireland

Type of case	**Outcome on impairment**
Review of Indefinite suspension - Performance	Impaired

Summary of outcome
Erasure

Tribunal:

Legally Qualified Chair	Miss Ruona Iguyovwe
Lay Tribunal Member:	Ms Morgan Phillips
Registrant Tribunal Member:	Dr Janet Nicholls

Tribunal Clerk:	Mr Andrew Ormsby (7 – 15/04/25) Mr Sewa Singh (3 – 4/07/25)

Attendance and Representation:

Doctor:	Present, not represented
GMC Representative:	Mr Terence Rigby, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Impairment - 15/04/2025

1. At this review hearing the Tribunal has to decide in accordance with Rule 22(1)(f) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules') whether Dr Weledji's fitness to practise remains impaired by reason of deficient professional performance.

Background

2. Dr Weledji received his primary medical qualification in 1992 from the National University of Ireland (University College, Dublin). In 1996, he became a Fellow of the Royal College of Surgeons of Edinburgh, and he also gained Fellowship of the Indian Society of Coloproctology in 2020.

3. Dr Elroy Weledji currently works as a Consultant General surgeon at the University of Buea, Limbe Hospital, Cameroon. In addition to the post of Consultant Surgeon in the specialty of general surgery and coloproctology, Dr Weledji is a Professor of Anatomy and Clinical Surgery and has interests in surgical oncology and coloproctology.

4. Dr Weledji started UK employment in 1992 after his qualification as a doctor in 1992 at University College, Dublin. He worked in a succession of medical jobs orientated towards training in surgery. In 1996 he was awarded the FRCS and commenced specialist registrar work. His UK work ceased in August 2000.

5. Dr Weledji was referred to the GMC in January 1999 by the Medical Director of Hairmyres and Stonehouse Hospitals NHS Trust raising concerns about the standard of Dr Weledji's professional performance. A GMC Performance Assessment took place in January and February 2001 which concluded that there had been widespread deficiencies in Dr Weledji's professional performance under the following headings:

1. assessment of patients' conditions;
2. providing and arranging treatment;
3. working within limits of competence;
4. respect for patients, trust and confidentiality;
5. providing and arranging investigations;
6. record keeping;
7. relationships with colleagues and deficiencies in team working;

8. arranging cover, delegation and referral; and
9. working within laws and regulations.

6. The Assessment Team, in 2001, formed the opinion that Dr Weledji should not continue as a practising surgeon. It recommended that he should limit his professional practice and retrain in a non-surgical field, and that his retraining should address his inability to perceive that he had limitations to his professional performance.

7. Dr Weledji's case was first considered in November 2001 when the Tribunal found the standard of his performance to be seriously deficient. The Tribunal determined to suspend Dr Weledji's registration for six months and gave him indications of the steps he should take in order to improve his performance. Dr Weledji's case was considered again in June 2002, June 2003 and June 2004. On each occasion the Tribunal found that there was no evidence that Dr Weledji had taken steps to improve his performance or had carried out any of the recommendations suggested at the previous hearings. As a consequence, in June 2004, the Tribunal suspended his registration indefinitely.

8. In March 2009, the Panel considered Dr Weledji's request that the indefinite suspension should be revoked. It noted that it had not received any independent or objective evidence to confirm that Dr Weledji had made any attempts to address the serious and widespread deficiencies that had been previously highlighted. There was no information or evidence to demonstrate that he had addressed the previously identified deficiencies in his practice or that he had developed any insight into the limits of his professional competence. It considered that if Dr Weledji's indefinite suspension were now to be terminated there would be an unacceptable risk to the safety of patients and the public interest. Consequently, in November 2009, Dr Weledji's application to terminate the indefinite suspension was dismissed and his registration continued to be indefinitely suspended.

9. On 23 September 2023, Dr Weledji wrote to the GMC to request a review of his indefinite suspension. He wrote that he wished to restore his licence to practise. He stated he left the UK about 20 years ago with full registration and an MBBChBAO (Dublin).

10. He stated in his correspondence that he had been *'castigated'* and treated unfairly for no genuine reason and informed the GMC that after he had returned home to Cameroon he had risen to the rank of Professor of Surgery. He stated that he would like to return to practise in the UK for the remainder of his working life.

11. On 1 December 2023 the GMC wrote to Dr Weledji informing him that, as more than two years had elapsed since his previous review hearings, it would be able to review his indefinite suspension and informed him that the relevant tribunal would have to receive objective evidence so it could assess his insight and remediation. It stated that this could include evidence that he had kept his skills up to date and that his return to unrestricted practice would not put patient safety at risk.

12. Dr Weledji was told to provide any evidence that he wished the Tribunal to consider as soon as possible, and that the MPTS would provide a date for the hearing.

13. On 19 December 2023, Dr Weledji sent his CV to the GMC which stated that he was a gastrointestinal surgeon in a regional hospital in Cameroon.

14. On 8 January 2024, Dr Weledji emailed the GMC stating that he had been unjustly treated for a variety of reasons. He stated that the original GMC decision to indefinitely suspend his registration had been flawed; that he had a number of qualifications, and that he had not harmed a patient in the UK. Further, he referenced an incident when, as a locum junior doctor in Scotland, he had been reprimanded for calling for help when he encountered uncontrolled bleeding whilst performing a haemorrhoidectomy. He stated that he had written a letter of complaint to the GMC regarding the attitude of the Consultant and that this had resulted in him being forced to attend a proficiency practical examination. He stated that this was the beginning of his professional *'downfall'*.

15. Dr Weledji stated that if the GMC looked critically into his treatment, it would see elements of racism and discrimination. Further, he stated that, as he was African and trained in Dublin, he had had no mentor in the UK, and neither had he been attached to a postgraduate deanery which could have assisted him. He stated that as he had returned home to Cameroon, he could not afford a legal defence and so did not appeal against the decision to suspend his registration indefinitely.

16. Following on from his request to the GMC, a Tribunal hearing was arranged to take place on 19 February 2024.

17. In February 2024 a Medical Practitioners Tribunal considered as a preliminary matter whether to adjourn the proceedings to direct that Dr Weledji should undertake a Performance Assessment to enable a Tribunal to obtain up to date objective evidence as to his professional performance.

18. The February 2024 Tribunal considered that, given that more than 20 years had elapsed since the previous Performance Assessment, and Dr Weledji stated he had been in surgical practice in Cameroon, and had also undertaken significant academic work, a new Performance Assessment would enable a Tribunal to make its determination based on objective, up to date evidence.

19. The February 2024 Tribunal directed that the GMC appoint a performance assessment Team and that a Performance Assessment should be completed by September 2024. The GMC was directed to issue Dr Weledji with a Performance Assessment Portfolio, which was to be completed by the doctor and returned by April 2024.

20. Before the Performance Assessment Dr Weledji was required to complete a work portfolio to help the assessors understand the context of his practice, and he was asked to provide evidence of his continuing professional development and the summary of his most

recent appraisal. He was told that the information he provided would be included in the assessors' report on his professional performance and would assist the assessors in planning the assessment and the GMC in making practical arrangements.

21. Dr Weledji subsequently provided a work portfolio to the GMC in which he stated his specialisms and qualifications. He also provided information relating to his employment history and publications.

22. The Performance Assessment took place over a period of three days in September 2024. A Performance Assessment report was completed by the Assessors with a database of their findings. Dr Weledji was assessed as a Consultant General surgeon.

23. The Performance Assessors were:

- Mr A, Consultant General Surgeon with an interest in colorectal surgery. He has been a Consultant since 2008 and has an operative practice that includes open, laparoscopic and robotic surgery. He has been a Performance Assessor since 2014 and team leader since 2017. He qualified as a doctor in 1995; and
- Mr B, Clinical Lead for Endoscopy at the Warwickshire Nuffield Hospital and a Clinical Appraiser of colleagues, former Clinical Director of Surgery, Royal College of Surgeons of England. He has over 30 years' experience as a doctor and 21 years as a Consultant in elective and emergency laparoscopic colorectal and general surgery.

Oral evidence

Evidence of Performance Assessors:

24. The Tribunal received oral evidence on behalf of the GMC from the Assessors, Mr A and Mr B.

25. The Assessors in their oral evidence explained why they had assessed Dr Weledji as a Consultant General Surgeon as set out in the assessment report. In answer to Dr Weledji's assertion that he wished to be assessed as a "basic surgeon", Mr A stated that there was no such concept as a basic surgeon in the UK, and so they were unable to assess him as such.

26. They said Dr Weledji described himself as a professor of general surgery, with an interest in coloproctology and oncology and stated that he had been working in this role in Cameroon for over a decade. The assessment team therefore determined that Dr Weledji should be assessed at the level of a UK Consultant General Surgeon with an interest in colorectal surgery.

27. They described the assessment process, the assessment tools used, the case based discussions, conclusions and recommendations and the findings and the reasons for their conclusions. They said the process was fair, not biased, and was conducted according to

standard criteria in the UK. Dr Weledji was assessed under a number of categories with reference to professional standards described in the GMC publication *Good Medical Practice*.

28. In response to Dr Weledji's contention that the assessment had taken place in a noisy environment, they denied having been aware of noisy surroundings. In relation to the assertion that Dr Weledji was hungry and not fed they stated that the timetable for the assessment included regular breaks and that lunch was provided.

29. They disagreed with Dr Weledji's view that the use of cadavers would make it difficult to demonstrate appropriate skills.

30. With respect to the case-based discussions and Dr Weledji's concern that the assessors had not raised all areas of concern with him during those discussions, the assessors said they focused on areas that they regarded as the most significant.

31. In response to Dr Weledji's complaints about the overall assessment, they explained how the overall assessment for each category was determined and how they had weighted their findings in reaching their overall conclusion. During their oral evidence, they highlighted findings made in categories where the overall assessment was marked as "unacceptable" or "cause for concern". They said the overall assessment may not correlate with the quantity of evidence regarding acceptable or unacceptable performance because the overall assessment takes account of patterns of performance and the importance of each item of evidence. Significant weight was given to areas of performance that put patients at risk.

32. The performance team found serious and persistent errors in Dr Weledji's practice across multiple assessment categories. The team found that his open surgical skills were unsafe. Dr Weledji's laparoscopic skills were also unsafe, but the team noted that Dr Weledji had insight into this aspect of his performance.

33. The team found evidence of unacceptable performance in the categories of assessment, management, skills, patients and colleagues. They stated that there were multiple instances within each of these categories where the team concluded that Dr Weledji's performance put patients at jeopardy. The combination of failings interacted in an adverse way, for example, ineffective clinical reasoning leading to ineffective history taking. The team noted that Dr Weledji's knowledge assessment was below average when tested and that he showed no good insight when asked to reflect on aspects of his performance.

34. The team's assessment was limited to simulated patient encounters as described because Dr Weledji does not work in the UK, and assessment at his current place of work was unfeasible. The team took account of Dr Weledji's unusual UK registration situation and judged his performance based on the description of practice that he gave and current UK expectations of Consultant General Surgeons.

35. The assessment took place in a GMC Clinical Assessment Centre in Manchester and Wrightington Hospital in Wigan and the components of the assessment were as follows:

'First Interview
The Team conducted a First Interview with Dr Weledji to gain a greater understanding of the context of practice. […]

Medical Record Review
The assessment team determined that Medical Record Review would not be feasible because the doctor was not working in the UK at the time of assessment.

Third Party Evidence
Third party evidence was not obtained for the performance assessment because Dr Weledji was not working in UK at the time of assessment.

Observation of Practice
Observation of Practice was not performed as Dr Weledji was not working in the UK at the time of assessment.

Case Based Discussion
The team chose eight cases to discuss with Dr Weledji, and several questions were asked about each. Cases were chosen from the Surgical Skills Assessment and the OSCEs.

During the discussion Dr Weledji was handed relevant OSCE or simulated surgery documentation to refresh memory. This included the task, patient details and records completed by Dr Weledji as part of the task.

Knowledge Test
Dr Weledji undertook a 2-hour test of 120 single best answer questions. The questions were chosen by members of the Tests of Competence and Revalidation Assessment Panel and were taken from the GMC item bank or sourced from the appropriate college. The test was invigilated by a GMC staff member. Prior to the test starting, the PAO went through the instructions and an example question with Dr Weledji to ensure he was comfortable with the format of the test.

36. The Performance Assessment also assessed Dr Weledji's surgical skills in the following way:

'Surgical Skills Assessment
Surgical skills were assessed in a simulated environment (a wet lab) because direct observation of surgery was not possible. The doctor does not work in the UK and the assessment of surgical skills is limited to simulation for other reasons, including patient safety.

The assessment was performed at the Wrightington Hospital on the 26th Sept 2024, using its cadaveric wet lab facility. The doctor was presented with an immersive

simulated experience that used technician support/role players to act in the role of assistant and scrub nurse. This simulation used prepared cadaveric material and surgical equipment of the type used in UK hospitals.

The assessments were:
1. Laparoscopic appendicectomy
2. Open left inguinal hernia repair
3. Laparotomy and small bowel resection and anastomosis

The assessment team determined that it was appropriate to assess Dr Weledji's performance at laparoscopic appendicectomy because the operation is commonly performed in the UK and because a competent Consultant General Surgeon would be expected to be able to perform the operation and also supervise more junior staff members to perform the operation.

At first interview Dr Weledji described his laparoscopic skills as 'limited' (FI1-102, F12-101, TOC25-100) however he said he had been on courses (FI1-109) and these are listed in his CV.'

37. The Performance Assessment set out the criteria used to assess each category:

How to read this section
This section of the report is divided by assessment category. In each category the Team have cited examples of the acceptable and unacceptable practice they've found and, where sufficient evidence exists, given an overall assessment of the doctor's performance. Their overall assessment may not correlate with the quantity of evidence regarding acceptable or unacceptable performance because the overall conclusion takes account of patterns of performance, and the importance of each item of evidence. ***Significant weight, for example, will be apportioned to evidence of performance that may put patients at risk****.* [Tribunal emphasis]

Not all items of evidence are used in the report. Instead, the Team Leader has studied all the data available and drawn out examples that are illustrative of the doctor's performance under that category. The examples chosen have been reviewed by the other assessors. The full database of evidence is appended to this report.

Overall assessments

The overall assessment for each category has been given according to the following scale:

Unacceptable indicates that there is evidence of repeated or persistent failure to comply with the professional standards appropriate to the work being done by the doctor, particularly where this places patients or members of the public in jeopardy (i.e. deficient professional performance). This grade should be entered if:

- *you have evidence that the criteria for an acceptable level of performance are regularly not being met or*
- *negative criteria are being met.*

Acceptable means that the evidence demonstrates that the doctor's performance is consistently above the standard described above. This grade should only be entered if:

- *all, or almost all, of the criteria are satisfied in all, or almost all, of the examples gathered.*

Cause for concern means that there is evidence that the doctor's performance may not be acceptable but there is not sufficient evidence to suggest deficient professional performance. The reasons for this grade, rather than 'unacceptable', should be described. This grade should be entered if:

- *there is evidence of some instances of unacceptable performance but which, in the view of the assessing team, do not amount overall to unacceptable performance.*

38. The Performance Assessment concluded that Dr Weledji's fitness to practise remained deficient. It stated that Dr Weledji is not fit to practise as Consultant General Surgeon with an interest in colorectal surgery because his practice would place patients at risk. The assessors placed weight on his inadequate surgical skills; inadequate relationships with colleagues; inadequate relationships with patients; and his inadequate patient assessment and management of patient's conditions.

39. Dr Weledji's performance was assessed under the following categories with the following overall assessment and by reference to the professional standards described in the GMC publication *Good Medical Practice* (GMP):

Category	Overall assessment
Maintaining Professional Performance	Cause for concern
Assessment of Patients' Condition	Unacceptable
Clinical Management	Unacceptable
Operative/Technical Skills	Unacceptable
Record Keeping	Acceptable
Relationships with Patients	Unacceptable

Working with Colleagues	Unacceptable

Evidence of Dr Weledji

40. Dr Weledji also gave oral evidence at the hearing.

41. In his oral evidence to the Tribunal, under cross-examination, he said he did not recall the 2001 Performance Assessment. He said he had been unjustly treated by the GMC for a variety of reasons as set out in his correspondence to the GMC (as outlined above). He stated that the original GMC decision to indefinitely suspend his registration had been unfair. He blamed it on the fact that he had brought a complaint to the GMC regarding the attitude of the Consultant. He stated that this was the beginning of his 'demise'.

42. In relation to the most recent Performance Assessment conducted in September 2024, he took exception to the decision of the assessors to assess him as a Consultant General Surgeon. He stated he wanted to be assessed as a '*basic surgeon'*.

43. He disputed the findings made by the Performance Assessors. He said he had been evaluated unfairly. He said that the assessors had not made sufficient allowance for the fact that different methods and equipment are utilised in Cameroon. He also highlighted the fact he qualified more than twenty years ago, and this had not been taken into account.

44. He described the assessors as biased and said the assessment was not holistic. He challenged the overall assessment of "unacceptable" in 5 out of 7 categories because he stated that he had been marked as acceptable in many elements of the assessment.

45. He said there must have been difficulty with communication and contended that the assessors must have misunderstood him because of his accent.

46. He criticised the assessors for including laparoscopy in the assessment procedures because he said he had told them in the first interview that he was not very good with using the laparoscopic equipment.

47. Dr Weledji also said he found one of the venues used for the assessment to be noisy. He said there were football fans making noise outside and he also referred to having been hungry. However, he accepted that he did not raise any of these complaints to the assessors at the time.

Documentary Evidence

48. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Committee on Professional Performance Notification of a Direction – 30 November 2001 (Hearing 26-28 November 2001);
- Committee on Professional Performance Notification of a Direction – 21 June 2002;
- Committee on Professional Performances Notification of a Direction – 20 June 2003;
- Committee on Professional Performance minutes of meeting - 4 June 2004;
- Fitness to Practise panel minutes - 11 November 2009;
- Record of Determination for hearing - 19 February 2024;
- Email correspondence between the GMC and Dr Weledji providing comments on the findings made in the 2001 and 2024 professional assessment reports - various dates;
- Letter from Dr Weledji with Performance Assessment Portfolio - 20 March 2024;
- Performance Assessment Portfolio, enclosing Dr Weledji's CV, dated 5 April 2024;
- Surgery logbook, various dates;
- Email correspondence from Dr Weledji to the GMC with attachments detailing his academic publications;
- Performance Assessment report – September 2024;
- Appendices to the Performance Assessment report and a database of findings – September 2024; and
- A bundle of documents from Dr Weledji outlining his basic surgical training.

Submissions

Submissions on behalf of the GMC

49. Mr Rigby submitted that, based upon the Performance Assessment, it was clear that Dr Weledji's fitness to practise was impaired, and the public interest required such a determination to be made.

50. Mr Rigby submitted that, whilst not conclusive, the Performance Assessment was the most convincing evidence that Dr Weledji's fitness to practise is impaired provided that the findings of the assessors were accurately recorded and that the assessment on the findings was objective, independent and reasonable. He submitted that there was no basis for doubting that the evidence of the assessors and the Performance Assessment report was reliable.

51. Mr Rigby submitted that Dr Weledji had provided no evidence, including in his own testimony, to cast any doubt on the Performance Assessment nor on its conclusion that the doctor is not fit to practise without restriction on his registration. He submitted that the only reasonable conclusion from the evidence is that Dr Weledji's fitness to practise is impaired.

52. He submitted that Dr Weledji's claims that the assessment was biased appeared to be based upon his belief that he is a competent indeed superior surgeon and could not have failed the assessment. Mr Rigby submitted that that was what the Performance Assessment was there to assess and the evidence is that Dr Weledji did fail. He submitted that Dr Weledji's claim that he was assessed on a wrong basis (too high too low) was confused and

not made out. He submitted that a registrar surgeon could and should have succeeded in the assessment, particularly in the operations. The assessments of his relations with patients and colleagues in the tests were not status specific and submitted that Dr Weledji failed because of his personality.

53. Mr Rigby submitted that Dr Weledji's complaints about the circumstances of the assessments e.g. too cold, too noisy etc were just excuses for his performance.

54. He submitted that Dr Weledji's problem with the Performance Assessment as with that in 2001 was that he had no insight into his own failings, as he demonstrated during the hearing.

55. He submitted that Dr Weledji's complaints were manifestly unfounded. On behalf of the GMC, he rejected all of Dr Weledji's criticisms about the Performance Assessment process.

56. In relation to Dr Weledji's evidence about his experience, expertise and competence as a surgeon, Mr Rigby submitted that it was overrated and provided no basis for doubting the assessment. He submitted that the evidence provided by Dr Weledji was essentially academic and where it touches on his own surgery is wholly self-reported.

57. He submitted that the only testimonials of Dr Weledji's practice are in reality in relation to him as an academic and do not relate to the issue under review. He submitted that the only reference in that testimonial to Dr Weledji as a surgeon which was sent "to whom it may concern" in 2018 was, in the GMC's submission, of negligible interest for this hearing. He submitted that apart from this reference, Dr Weledji had provided no testimonials or anything independent or objective about his surgery.

58. He submitted that the Performance Assessment is clearly reliable and compelling evidence of the impairment of Dr Weledji's fitness to practise. He stated that Dr Weledji's comments about the assessment were underwhelming and demonstrate his complete lack of insight into his deficiencies. He stated that Dr Weledji's evidence about his career as a surgeon without any independent or objective support is equally underwhelming.

59. Mr Rigby referred to the Performance Assessment, in particular to the summary and recommendations which, he stated, made it clear that Dr Weledji's fitness to practise without restriction is impaired by the measure of a Consultant General Surgeon. He also drew the Tribunal's attention to Dr Weledji's failure to reach an acceptable standard in five of the seven categories which meant that the doctor's performance was mostly unacceptable or unacceptable on the most important aspects of the assessment.

60. Further, Mr Rigby submitted that, *'most importantly'*, the assessors concluded that Dr Weledji's surgical skills were unsafe. He went on to quote the Performance Assessment, in particular its findings that there were multiple instances within each of the categories where the doctor's performance put patients in jeopardy.

61. Mr Rigby concluded by emphasising that the assessors *'were wholly credible and obviously reliable'* and that the criticisms made of them by Dr Weledji were dealt with *'wholly convincingly'* by the assessors when they gave oral evidence at the hearing.

Dr Weledji's submissions

62. Dr Weledji in his submissions to the Tribunal repeated all the points set out above in his oral evidence.

63. He also submitted that he thought that the assessment had been fair but that he thought that evaluation of the assessors was unfair and that they had judged him too harshly.

64. He stated that the assessors had not given him the chance to explain why he had chosen some of the methods he used and made the decisions he made. He accused the assessors of '*not opening up'*. He said if the assessors had raised all their concerns with him, he would have been able to explain why he had chosen the methods he used and made some of the decisions he took, which could have led to a different overall assessment in the different categories.

65. He disputed some of the findings in the Assessment Report and accused the assessors of "lying". He said he could not accept that he had made some of the mistakes outlined. He submitted they should have showed him all of their observations before he left the assessment venue rather than discussing it between themselves afterwards.

66. He accused the assessors of bias but did not provide any detail as to how this had manifested.

67. He went on to state that he had not failed the Performance Assessment and that the conclusions of the assessors were not fair. He submitted that the assessors had not paid sufficient attention to the things he got right and neither had they paid enough attention to the fact that his qualifications were obtained twenty years ago.

68. During his evidence and in his submissions he also complained about the use of cadavers stating this affected his ability to demonstrate the professional skills required.

69. He emphasised his experience, qualifications and his academic publications. He submitted that the assessors in making their assessments had not taken account of his academic background and had not paid enough attention to all of his publications. In his submissions, he told the Tribunal that he was involved in carrying out surgery for a number of the cases mentioned in the publications he supplied to the GMC.

70. He also submitted that he had been assessed on an inappropriate basis, sometimes by too high a standard as he felt that he should have been assessed as a '*basic surgeon'* and

also said that sometimes he was assessed by too low a standard. He described many of the procedures that were used in the Performance Assessment as "basic".

71. He submitted that the assessors were not independent – he said they were colluding with each other. He stated that he thought they wanted to preserve the 'status quo' but he did not explain what their motivation for this was.

72. Dr Weledji stated that the Performance Assessment itself had taken place under unsatisfactory conditions. He stated that the assessment had taken place under cold and noisy conditions and that it had been difficult to reach the assessment venue. He complained about a publication by the GMC on its website that he was not eligible to carry out surgeries in the UK due to his indefinite suspension shortly before the Performance Assessment. He said the publication caused him embarrassment and all of those matters contributed to him being stressed just before the Performance Assessment took place.

The Relevant Legal Principles

73. The Tribunal reminded itself that the decision of impairment is a matter for the Tribunal's judgement alone. As noted above, the previous Tribunal set out the matters that a future Tribunal may be assisted by.

74. This Tribunal must determine whether Dr Weledji's fitness to practise is impaired today, taking into account Dr Weledji's performance at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

75. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to deficient professional performance and then whether the finding of that deficient professional performance could lead to a finding of impairment.

76. Whilst there was no statutory definition of 'deficient professional performance' guidance can be found in the case of *Calhaem v* GMC [2007] EWHC 2606 (Admin):

> *'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.'*

77. The Tribunal had regard to the case of *CHRE v NMC and Grant* [2011] EWHC 927.

78. In considering its approach to the evidence, the Tribunal was directed to the case of *Roy v General Medical Council* [2023] EWHC 2659 (Admin), which states that

when a doctor and a witness provide fundamentally incompatible versions of events, the tribunal can determine credibility and reliability against the background of any admissions by the parties; the contemporaneous documents (which can be damning for a party and undermine their evidence in chief); and any consistencies and inconsistencies in their evidence.

79. The Tribunal was directed to the case of *Goodchild-Simpson v GMC* [2013] EWHC 1343 (Admin), a case in which a practitioner had raised challenges in relation to the adequacy of sample cases chosen by assessors and the fairness of the Performance Assessments.

80. The Tribunal was also directed to the case of *Nagiub v GMC* [2013] EWHC 1766 (Admin), a decided case which involved a review hearing involving Performance Assessments where the practitioner challenged the evidence of the Performance Assessors and mounted criticisms of the Performance Assessment processes used.

81. The Tribunal was directed to the decisions made on appeal in relation to the approach taken in both cases in considering the evidence of the Performance Assessments. The Tribunal was reminded that each case is to be treated on its own merits but the same approach can be taken in considering this case.

82. The Tribunal was directed to consider the criticisms of the Performance Assessment and the assessors made by Dr Weledji and decide whether the conclusions reached by the assessors were flawed or whether the process used by them was undermined by some procedural impropriety or breach of natural justice. The Tribunal was required to decide which evidence it prefers, that given by Dr Weledji or that provided by the Performance Assessors. When doing so the Tribunal was asked to consider the fact that there were contemporaneous notes made by the assessors during the assessments which may be considered to provide some support for their evidence. It is also relevant in this case that the assessors were experienced surgeons. They have given evidence about the process and the decisions they made about choice of case-based discussions and matters of their own clinical judgement. It is for the Tribunal to decide if their evidence is credible and/or reliable.

83. The Tribunal was reminded that throughout the decision-making process it must bear in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

84. The Tribunal was then directed to the relevant legal framework and procedure that applies for a review hearing set out in section 35D of the Medical Act 1983 and Rule 22 of the Rules.

85. In the case of *Abrahaem v GMC* [2008] EWHC 183 (Admin), Blake J described the procedure as *'an ordered sequence of decision making'*. In that case, the Tribunal was

reviewing the appellant's suspension under the regime prescribed by section 35D of the Medical Act 1983.

86. At this stage, the Tribunal must first address the question of whether fitness to practise is impaired. In doing so *'the review has to consider whether all the concerns raised in the original finding of impairment … have been sufficiently addressed to the Tribunal's satisfaction'*.

87. In practical terms there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments.

88. In considering whether a practitioner's fitness to practise is impaired, the Tribunal will consider if it has received any evidence that the practitioner has taken any steps to remediate. The Tribunal will consider whether the practitioner has demonstrated any insight into the deficient professional performance. Insight is crucial to remediation because lack of insight could lead to a risk of repetition.

89. The Tribunal needs to consider whether Dr Weledji continues to be impaired: see the cases of *Shah Shahin Ali v GMC* [2023] EWHC 2400 (KB); *Yusuf v GMC* [2018] EWHC 13 (Admin); *Sawati v GMC* [2022] EWHC 283 (Admin); and *Nagiub v GMC* [2013] EWHC 1766 (Admin).

90. The case of *Shah Shahin Ali V General Medical Council* [2023] EWHC 2400 (KB) also provided a reiteration of some of the principles from the case of *Yusuf v GMC* [2018] EWHC 13 (Admin), that in review hearings:

- the findings of fact are not to be re-opened;
- a practitioner is entitled not to accept the findings of the tribunal. In the alternative, they are entitled to say that they have accepted the findings in the sense that they do not seek to go behind them, while still maintaining a denial of the conduct;
- when considering whether a practitioner's fitness to practise remains impaired, it is relevant for the tribunal to know whether or not the practitioner now admits the misconduct, but admission is *not* required to establish that they understood the gravity of the offending and are unlikely to repeat it;
- if it is made apparent that the practitioner did not accept the truth of the findings, questioning should not focus on the denials and the previous findings;

- a want of candour and/or continued dishonesty at the review hearing may be a relevant consideration in reviewing impairment.

The Tribunal's Determination on Impairment

Does Dr Weledji's Fitness to practise remain impaired?

91. Fitness to practise – the public is entitled to expect that their doctor is fit to practise and follows the principles and standards set out in the Good Medical Practice. Where a doctor has not met the standards expected of them, fitness to practise may be found to be "impaired". There is no complete statutory definition of Impaired Fitness to Practise. A doctor's fitness to practise can only be regarded as impaired under Section 35C (2) of the Medical Act 1983, a person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of:

a) Misconduct;
b) Deficient Professional Performance;
c) A conviction or caution …
d) Adverse physical or mental health; or
[…]

92. The relevant section that is applicable here is: Deficient Professional Performance.

93. In *Meadows v GMC Court of Appeal* (Civil Oct 26, 2006) [2006] EWCA Civ 1390 it was stated: *"The purpose of Fitness to Practise Proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The Fitness to Practise Panel thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evidence that it will have to take account of the way in which a person concerned has acted or failed to act in the past…"*.

94. In *Ziderman v General Dental Council [1976] 1 WLR 330 at 333*, Lord Diplock giving the judgment of the Privy Council said: *"The purpose of disciplinary proceedings against a dentist who has been convicted of a criminal offence by a court of law is not to punish him a second time for the same offence but to protect the public who may come to him as patients and to maintain the high standards and good reputation of an honourable profession"*.

95. Whilst there is no statutory definition of impairment, the Tribunal will be assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC and Paula Grant* [2011] EWHC 297 Admin, which requires to tribunal to consider whether its 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 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 committed a breach (other than one which is trivial) of one of the fundamental tenets of the medical profession and/or is liable to do so in the future and/or
d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.

96. In reaching its determination on whether Dr Weledji's actions amounted to deficient professional performance, the Tribunal first reminded itself of the background to Dr Weledji's case.

97. The Tribunal noted that in January 1999 the Medical Director of Hairmyres and Stonehouse Hospitals NHS Trust raised concerns about the standard of Dr Weledji's professional performance.

98. A GMC Performance Assessment took place in January and February 2001 which concluded that there had been widespread deficiencies in Dr Weledji's professional performance under the following headings:

1. assessment of patients' conditions;
2. providing and arranging treatment;
3. working within limits of competence;
4. respect for patients, trust and confidentiality;
5. providing and arranging investigations;
6. record keeping;
7. relationships with colleagues and deficiencies in team working;
8. arranging cover, delegation and referral; and
9. working within laws and regulations.

99. The 2001 Assessment Team formed the opinion that Dr Weledji should not continue as a practising surgeon. It recommended that he should limit his professional practice and retrain in a non-surgical field, and that his retraining should address his inability to perceive that he had professional limitations.

100. The 2001 Committee also found Dr Weledji's performance to be unacceptable in:

a. *Assessment of patients' conditions: The Committee consider that patients may have been placed at risk by Mr Weledji's inadequate assessment of their conditions. This included deficiencies in history taking, examination and the use and interpretation of other data* […].

b. Providing and arranging treatment: The Committee have determined that on a number of occasions Mr Weledji's provision of treatment was inappropriate […].

c. Working within limits of competence: The Committee have based their finding of unacceptable on the evidence from a number of sources particularly Mr Weledji's lack of insight into his limitations as a surgeon as set out in his own letters, the case of delay in help being called when complications were encountered during a haemorrhoidectomy and the transcript of [Mr C's] interview. They also had regard to the letter from Nevill Hall Hospital of 4 May 1999 in which Mr Weledji was given a formal written warning about taking a patient to theatre without telling the consultant

101. The 2001 Committee found that:

'Nothing in the evidence suggests that Dr Weledji accepts that his professional performance has been in any way deficient. They have determined that Dr Weledji lacks insight into the limits of his professional performance and that as a result, if he were to continue in medical practice, he would present a significant risk to patient safety'

102. The Tribunal noted that the 2002 Committee stated that it had no evidence before it that Dr Weledji had carried out any of the 2001 Committee's recommendations for retraining and directed that the doctor's registration be suspended for a further 12 months. It noted that findings of the previous 2001 Committee indicated that Dr Weledji lacked insight into the limits of his professional competence, and that the concerns about his professional performance were serious and widespread. It considered that if allowed to practise without remedial training he would present a significant risk to patient safety.

103. The Tribunal further noted that the 2003 Committee 'noted with concern' that there was no evidence that Dr Weledji had taken steps to improve his performance and no evidence that indicated that he had carried out any of the recommendations suggested at the previous hearing.

104. The Tribunal also considered that findings of the 2004 Fitness to Practise Panel (2004 Panel), namely that Dr Weledji lacked understanding of the limits of his professional competence and that the concerns about his professional performance were serious and widespread. It also noted the 2004 Panel findings that Dr Weledji had provided no evidence which demonstrated that he had carried out any of the recommendations outlined by the previous Committees and imposed an indefinite suspension upon his registration.

105. The Tribunal also noted the 2009 Panel's decision to refuse Dr Weledji's request for his indefinite suspension to be revoked, and its finding that the doctor had not provided it with any independent or objective evidence to confirm that he had made any attempts to address the serious and widespread deficiencies that have been highlighted by the previous

Committees. The 2009 Panel also found that Dr Weledji provided no evidence to show what efforts he has taken to develop his understanding and insight into the limits of his professional competence.

Tribunal's findings in relation to 2024 Performance Assessment Report

106. The Tribunal then directed its attention to the Performance Assessment conducted in September 2024 and the evidence given by the Performance Assessors and Dr Weledji.

107. The Tribunal also considered the submissions made by the GMC and by Dr Weledji.

108. The Tribunal considered Dr Weledji's criticisms of the Performance Assessors and their Report and his assertion that they were lying about some of their reported findings. The Tribunal found these criticisms to be unfounded. The Tribunal found the evidence of the Performance Assessors to be accurate, credible and reliable. The Tribunal preferred the evidence of the Assessors to that of Dr Weledji. The Tribunal took into account the fact that the findings made by the Performance Assessors were supported by clear reasons, which were set out in the assessment database that contained contemporaneous notes made during their assessments. The Tribunal also took into account the evidence given by the assessors and matters set out in the Performance Assessment Report and the findings and reasons in the accompanying database about how they had achieved the overall assessments and the way they had weighted matters that presented risks to patient safety in making those overall assessments. The Tribunal concluded that the criticisms made by Dr Weledji were neither reasonable nor convincing.

109. The Tribunal accepted the evidence of the Performance Assessors that Dr Weledji was assessed against clear standard criteria in the UK applying the GMC publication "Good Medical Practice' and the Performance Assessment was conducted in a professional manner by experienced surgeons in Dr Weledji's field of practice.

110. The Tribunal considered Dr Weledji's submissions that the assessment was biased and unfair, that the assessors wanted to maintain the '*status quo'* regarding his registration. The Tribunal noted that Dr Weledji had provided no evidence of the bias he alleged and nothing to suggest a motive for the Assessors to behave in such a way. The Tribunal found no evidence of bias or unfairness in the way that the Performance Assessment was conducted and the conclusions reached.

111. The Tribunal considered Dr Weledji's submission that the Assessors had colluded and were not independent. The Tribunal's finding based on the evidence it received was that the Performance Assessors had worked as a team with Mr A as the team leader. They were however independent of the parties. The evidence considered by the Tribunal showed that the Performance Assessors were broadly in agreement about their findings in relation to Dr Weledji's performance. The Tribunal found no evidence of them colluding to reach any specific adverse findings as alleged by Dr Weledji.

112. Overall, the Tribunal was satisfied that Dr Weledji's Performance Assessment was fair.

113. The Tribunal considered Dr Weledji's objection to the decision made by the Performance Assessors to assess him as a Consultant General Surgeon. The Tribunal noted the evidence given by the Performance Assessors about the reason why they had made that decision as outlined above in the evidence of the Assessors and accepted the rationale for having done so. In particular the Tribunal noted that Dr Weledji, had by his own account, been working as a Consultant General Surgeon for more than a decade.

114. The Tribunal considered Dr Weledji's submissions that the Performance Assessors had not discussed all their concerns in the case-based discussions and that if they had raised certain matters, he would have been able to explain the choices he made and decisions taken and this would have changed the overall assessment in those categories. The Tribunal noted the evidence of the Performance Assessors about the way they decided the matters that were discussed in the case-based discussions. This was a matter for their clinical judgment based on what they considered the most significant. The Tribunal found no support in the evidence for Dr Weledji's belief that the Assessors would have changed their overall Assessment if he had been able to explain the matters set out by him to them.

115. The Tribunal considered Dr Weledji's criticism of the use of a cadaver during the surgical scenarios. The Tribunal noted the evidence of the assessors that they used freshly frozen cadavers and this is an acceptable standard assessment tool in the UK, which in their opinion does not affect the candidate's ability to demonstrate the required skills.

116. The Tribunal acknowledged Dr Weledji's assertion that different surgical methods are currently being used in Cameroon. It accepted the Assessors' evidence that, as Dr Weledji is applying to work in the UK, he would be expected meet current UK clinical methods.

117. The Tribunal also considered Dr Weledji's assertion that the choice of surgical scenarios used in the Performance Assessment had been basic and *'below his standard'.* It further noted that Dr Weledji had also claimed that the surgical scenarios were not holistic in that they had not paid enough attention to what he had 'got right' rather than what he had 'got wrong'.

118. The Tribunal noted the evidence of the Performance Assessors about these criticisms. These were matters for their clinical judgment. Both Assessors are experienced surgeons. The Tribunal accepted the evidence of the Assessors as to why they had focused their findings in the way that they did. The Tribunal also noted and accepted the GMC's submission that Dr Weledji's position on this appears to be somewhat confused. On the one hand he has complained about being assessed as a Consultant General Surgeon but on the other hand he complained that the Performance Assessment was below his standard.

119. The Tribunal further noted that Dr Weledji had asserted that there may have been communication difficulties due to his accent. There was nothing in the evidence of the assessors or the assessment database to show that there had been difficulties in

communicating with Dr Weledji. Most of the findings of the Assessors were directed towards what he did or did not do and to the contents of what he said.

120. Dr Weledji complained that the assessors had not taken account of his academic qualifications and publications. The Tribunal noted that Dr Weledji had submitted his Work Portfolio setting out his qualifications and publications to the assessors before the Performance Assessment and the assessors in their oral evidence acknowledged Dr Weledji's portfolio and stated they had taken this into account when deciding upon the testing criteria to be used in the Performance Assessment. However, they emphasised that they were assessing him not for his academic qualifications but for his clinical practice as a Consultant General Surgeon.

121. Dr Weledji complained that the Assessors did not take account of the fact that he had passed his examinations over 25 years ago.

122. The Assessors stated in response to this, and the Tribunal noted, that GMP requires practitioners to be competent in all aspects of their work (para 1) and to keep their professional knowledge and skills up to date (para 11). Dr Weledji is expected to maintain his professional knowledge and skills.

123. In relation to Dr Weledji's evidence about his experience, his clinical expertise and practice as a surgeon, the Tribunal considered the material submitted by Dr Weledji and submissions made by both Dr Weledji and by the GMC. The Tribunal considered a number of publications by Dr Weledji. The Tribunal considered the submissions made by Dr Weledji about his own role in carrying out the surgery involved in some of those publications. The Tribunal concluded that the evidence provided by Dr Weledji was largely academic and in relation to items that touched on surgery, was self-reported apart from the employment references referred to in the GMC's submissions above.

124. Dr Weledji provided an employment reference letter, undated, from the Director of the Regional Hospital, Limbe, Cameroon, addressed '*to whom it may concern*' and it states that it provides a '*clinical report*' for Dr Weledji, senior lecturer in the Department of Surgery, Faculties of Health Sciences, University of Buea, regarding the change of his grade to that of an associate professor. The Tribunal really found limited or no evidence to support Dr Weledji's own evidence about his clinical practice in this document or similar references in the documents provided.

125. There is a reference to the fact that Dr Weledji is '*assiduous and performs all clinical duties assigned to him by the hospital hierarchy. In addition to his responsibility as clinical lecturer to the medical students of the university of Buea. He is actively involved in the promotion of continuing medical education of the medical staff in the hospital*'. The Tribunal noted that this same phrase is used in the other references from Dr Weledji which appear to be from different authors. The Tribunal felt unable to attach weight to these broad assertions without more details.

126. There were no references or testimonials, or independent objective evidence provided to the Tribunal to support Dr Weledji's clinical practice. There was no evidence provided to the Tribunal by Dr Weledji to undermine the findings made in the various Performance Assessment reports that had been conducted. The Tribunal therefore concluded that it could not accord much weight to the evidence provided by Dr Weledji about his clinical experience.

127. The Tribunal considered Dr Weledji's complaints and objections to the fairness of the Performance Assessment on the grounds of the cold weather and noise from football fans outside. The Tribunal took account of the evidence of the Assessors. The Assessors dispute what Dr Weledji has set out. The Tribunal was directed to the positive feedback provided by Dr Weledji to the Assessors after the assessment process. The Tribunal did not find Dr Weledji's evidence on this to be credible. The Tribunal concluded that Dr Weledji had been treated in the same manner as any other registrant undergoing a Performance Assessment.

128. The Tribunal noted some particular scenarios, in particular in the finding in relation to 'Assessment of Patients' Condition':

> *'Dr Weledji's performance in the category of Assessment of Patients 'Condition is found to be unacceptable. There is evidence of repeated failure to comply with the professional standards appropriate to the work of a consultant general surgeon. The criteria for an acceptable level of performance are regularly not being met. Dr Weledji's performance places patients at risk.*
>
> […]
>
> *Dr Weledji's patient assessment was not safe and effective and thereby exposed patients to harm. Simple common scenarios such as dysphagia and its oesophageal cancer risk were not recognised (OSCE 7) and AKI was misdiagnosed as haemorrhage (OSCE 10). A consultant surgeon is expected to be accurate. Dr Weledji's approach often lacked structure even though he appreciated the need for this (e.g. using ABCDE approach trauma and acutely deteriorating*
> *patients). The team considered that failure to use ABCDE structure consistently put patients at risk.'*
>
> […]
>
> *In OSCE 7 (a patient with dysphagia), Dr Weledji's clinical reasoning was incorrect when he concluded that the patient had a benign oesophageal stricture in the setting of red flag symptoms that should have made him draw a conclusion or have a significant concern about the possibility of cancer* […]
>
> *Dr Weledji's ability to diagnose patients put them at risk because his diagnoses were inaccurate and ill-founded. His misdiagnosis led to serious errors later in the clinical*

process (see Investigation for OSCE 7 or Management for OSCE 11) and were judged as unacceptable overall'

129. Further, the Tribunal also noted the Performance Assessment's conclusions in relation to 'Operative/Technical Skills', in particular:

> *Open repair of inguinal hernia technique*
> *Dr Weledji roughly dissected tissues (TOC26-102, TOC26-110, TOC29-106) and the assessors judged this unacceptable because of the risk of bleeding and risk of unnecessary tissue injury.*
>
> *Dr Weledji was judged to be unacceptably slow to operate given the cadaver's anatomical circumstances and the standard was not that of a consultant level operation (TOC26-124, TOC26-122).*
>
> *Dr Weledji claimed to have seen and preserved the ilioinguinal nerve but the assessors were not convinced the structure had been safely preserved (TOC26-109, TOC29-108). This was judged unacceptable.*
>
> *Dr Weledji did not perform an adequate exploration of the spermatic cord, inguinal canal or deep ring. This was judged unacceptable because small hernia's can be missed at these sites; his performance was therefore judged unacceptable because of the risk of recurrence (TOC29-111, TOC26-112).*
>
> *Dr Weledji's schema for hernia repair was not well aligned with contemporary surgical practice and therefore judged unacceptable. For example, he said he would use a 'Bassini' repair, which is now deprecated (TOC26-107, TOC26-120, CBD5-205, CBD5-206). Similarly, he plicated the transversalis fascia in the absence of a direct defect, which is illogical and therefore was judged unacceptable (TOC26-127, TOC26-115).*
>
> *A good quality repair would fix a mesh of adequate size to the posterior wall of the inguinal canal and reconstruct the deep ring, without tension. Dr Weledji's repair did not effectively fix the mesh at its margins and thereby risked mesh retraction, recurrence and pain (TOC26-118, TOC26-114, TOC26-119, TOC26-120, TOC26-121, TOC29-112, TOC29-113); it was judged unacceptable. The team assessed the doctor's clinical reasoning about his operative repair at case based. The team assessed the doctor's clinical reasoning about his operative repair at case based discussion (CBD5) and judged that his answers lacked logic or a good justification (CBD5-207, CBD5-208, CBD5-203, CBD5-201, CBD13-200, CBD13-206). The assessors discussed the repair at report writing day and agreed that the repair performed had a raised risk of recurrence and surgical complications (e.g. haematoma due to bleeding). Overall, the assessors judged his hernia repair to be unacceptable because of the risk of recurrence and complications.*

Dr Weledji did not perform a subcuticular skin closure, which helps patients because sutures are not required to be removed post-operatively (TOC29-116, TOC26-125). This was judged unacceptable.

[…]

Small bowel anastomosis
Dr Weledji performed an end-to-end two layer anastomosis; at the end of the operation the assessors checked for the presence of a palpable lumen and found none (TOC30-119, TOC27-113, TOC27-108); they judged this as unacceptable. The repair was judged unacceptable and dangerous because of the risk of anastomotic leak and bowel obstruction. A good repair would have palpable lumen at the conclusion of the procedure to permit the egress of gut contents from the proximal bowel to the distal bowel though the anastomosis.'

130. The Assessors concluded in relation to operative technical skills:

'The overall assessment for this was unacceptable. The assessors found evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of a consultant surgeon. They found that Dr Weledji's performance put patients at risk. The performance team were concerned about persistent serious errors that Dr Weledji made during his operations: his laparoscopic skills are unsafe; he did not follow safety protocols (e.g. WHO check, antibiotic administration); his open dissection technique was rough and inaccurate; his small bowel anastomosis was unsafe; and, his inguinal hernia repair ineffective. His overall performance did not meet that expected of a consultant general surgeon.'

Good Medical Practice requires that a number standards are met:

1 You must be competent in all aspects of your work.

11 You must keep your professional knowledge and skills up to date

6 You must provide a good standard of practice and care

2 You must recognise and work within the limits of your competence.

The assessment team noted that Dr Weledji had declared at First Interview that he had limited laparoscopic skills (F12-101, F12-100, FI1-102, F11-109). They also recognised that the assessment of surgical skills was a simulated exercise, so, in a formative sense the exercise is '*safe-to-fail*', because no harm could occur because of the assessment. They therefore judged that assessment of his laparoscopic skills was a reasonable request during the Performance Assessment.

They concluded that Dr Weledji's performance during open surgery (open appendicectomy, inguinal hernia repair and small bowel anastomosis) persistently and seriously departed from GMP (para 1,2 and 6). Furthermore, Dr Weledji does not have the laparoscopic skills required of a UK accredited Consultant General Surgeon and has therefore not met the requirement of paragraph 11 of GMP *"You must keep your …skills up to date*".

The assessment team discussed Dr Weledji's performance and concluded that it was dangerous.

131. The Tribunal also noted the Assessors findings on Clinical Management, which involves providing treatment, advice or a referral of patients, safety netting, investigations as part of follow-up or ongoing care, and working within limits of competence.

132. Dr Weledji's performance in the category of Clinical Management was found to be unacceptable. In this area the assessors found evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of a Consultant General Surgeon. They found that Dr Weledji's performance placed patients at risk.

133. The assessment team were concerned about Dr Weledji's prescribing and this evidence apportioned weight to their overall opinion.

134. The assessment team discussed Dr Weledji's prescribing at report writing day and considered that overall, his prescribing was unacceptable because it was inaccurate, unnecessary and unsafe in some situations, for example, when prescribing blood, oxygen and diclofenac to vulnerable patients. The team attached weight to the autonomy of patients and their inability prevent drug administration because of general anaesthesia (Surgical Procedure 2 and 3) or reduced mental capacity due to acute illness (OSCE 11, shock) or young age (Surgical Procedure 1). The errors were therefore considered serious and persistent; patients were put at risk.

135. The overall assessment of Dr Weledji's performance in the category of Working with colleagues, was found to be unacceptable. This involved a consideration of multi-disciplinary teamwork, leadership, communication (including written communication), teaching and supervision. The assessors found evidence of repeated and persistent failure to comply with the professional standards appropriate to the work of a Consultant General Surgeon. They concluded that Dr Weledji's performance placed patients at risk. They found persistent and repeated examples of Dr Weledji's interactions with colleagues putting patients at risk.

136. Dr Weledji did not act decisively when managing a colleague with alcohol problems. He undermined collegiate relationships and working by providing inaccurate information when negotiating a theatre slot. He had stated that a patient was dying when this was not the case. He did not acknowledge operating room staff stress and the contribution of his behaviour to this.

137. The team discussed and weighed the evidence and determined that Dr Weledji's work with his colleagues was unacceptable and put patients in jeopardy.

138. The Tribunal noted the findings and conclusions of the Performance Assessment, and the reasons given by the Assessors for those findings. The Tribunal concluded that there were clear deficiencies in Dr Weledji's practice which amounted to deficient professional performance. In reaching that conclusion the Tribunal had regard to the following paragraph of GMP:

> *'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.'*

Impairment

139. The Tribunal, having found that it was satisfied with the fairness of the conclusions of the Performance Assessment, and that those conclusions amounted to deficient professional performance, went to consider whether Dr Weledji's fitness to practise remained impaired by reason of the deficient professional performance.

140. In considering whether a practitioner's fitness to practise remained impaired, the Tribunal considered whether Dr Weledji had demonstrated any insight into his deficient professional performance and if it had received any evidence to show that Dr Weledji had taken steps to remediate.

141. The Tribunal reminded itself that insight is crucial to remediation because lack of insight could lead to a risk of repetition.

142. There is a persuasive burden on Dr Weledji at this review hearing to demonstrate that he has fully acknowledged why his past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments.

143. The Tribunal concluded that it had received no evidence to show that Dr Weledji has fully acknowledged any of the previous concerns about his deficient professional performance as set out above. He has persistently failed to acknowledge the findings made about his deficient professional performance both in the past and in the most recent Performance Assessment as outlined above. His failure to acknowledge them means that he has failed to address them. Dr Weledji has stated that the Performance Assessors should have made allowances for the fact that he obtained his qualifications over twenty years or so ago.

144. The onus is on Dr Weledji to demonstrate that he has kept his medical knowledge and skills up to date and is safe to resume unrestricted practice. The Tribunal recognised that Dr

Weledji will not have had clinical contact with patients in the UK since he was suspended from the register. The Tribunal evaluated the evidence provided by Dr Weledji to determine whether the steps taken by him to keep skills and knowledge up to date were adequate to allow a return to full unrestricted practice. Doctors may demonstrate that they have maintained their clinical knowledge and skills in a variety of ways such as through undertaking clinical placements and/or observing clinical consultations, attending relevant training courses in person and through overseas practice.

145. In this case the Tribunal was not satisfied from the evidence it received on behalf of Dr Weledji that he had kept his clinical skills up to date and that he was safe to resume unrestricted practice in the UK.

146. The Tribunal noted that Dr Weledji had provided no evidence of reflection or remediation and had not accepted the findings of the Performance Assessment. It further acknowledged that he also continued to reject the findings of the 2001 Performance Assessment and previous 2001 Committee, 2002 Committee, 2003 Committee and 2004 Panel. He has failed to accept the findings of the Performance Assessment conducted in 2024, instead accusing the assessors of lying and of being biased and wanting to preserve the "status quo".

147. There was no evidence of insight or remediation on the part of Dr Weledji. He has not acknowledged previous concerns raised, instead he has persistently undermined them by his comments including by his oral evidence to the Tribunal and written communication to the GMC. There had been no reflection or recognition of deficient professional performance in this case, nor was there any evidence that Dr Weledji understands the gravity of his impairment.

148. The Tribunal considered whether there was a risk of repetition. In doing so, it took account of the circumstances that gave rise to the concerns, what steps Dr Weledji had put in place to avoid the circumstances arising again, whether there was evidence of remediation. The Tribunal concluded that given there was a complete lack of insight and no evidence of remediation and nothing to show that Dr Weledji had learnt from any of the findings made relating to his deficient professional performance, there was therefore a significant risk of repetition in his case.

149. The Tribunal then considered the statutory overarching objective.

Will a finding of no impairment meet the overarching objective?

150. Having made the above findings as to whether Dr Weledji's fitness to practise remains impaired, the Tribunal next had regard to the statutory overarching objective. In so doing, it performed a balancing exercise, weighing its findings above with its obligations under the individual limbs of the statutory overarching objective which are:

- To protect, promote and maintain the health, safety and well-being of the public

- To promote and maintain public confidence in the profession, and

- To promote and maintain proper professional standards and conduct for members of that profession.

151. The Tribunal was mindful of the findings of deficient professional performance that led to Dr Weledji's suspension in 2001 and the subsequent findings made since. The Tribunal reminded itself of the findings made in the latest Performance Assessment Report and its conclusion that Dr Weledji does not have insight into his deficient professional performance, has not remediated and that he has not kept all of his medical skills up to date according to the UK standards.

152. The Tribunal reminded itself of the findings made in the latest Performance Assessment, in particular it had regard to the conclusions. Dr Weledji was assessed as a Consultant General Surgeon and he failed to reach an acceptable standard in five out of the seven categories. Dr Weledji's performance was mostly unacceptable or unacceptable on the most important aspects of the assessment. The assessors concluded that Dr Weledji's surgical skills were unsafe. The Performance Assessors found serious and persistent errors in Dr Weledji's practice across multiple assessment categories which resulted in patients being put at risk.

153. Based on the findings of the 2024 Performance Assessors, the Tribunal determined that there would a risk to patient safety if Dr Weledji were to return to unrestricted practice in the UK.

154. The Tribunal considered that a medical practitioner practising as a surgeon at a level deemed to be unacceptable and potentially putting the public at risk would undermine the public's trust in the profession.

155. The Tribunal determined that the public expects doctors' conduct to justify its trust in them and expects doctors to perform at an appropriate performance level. Where doctors fail to do so in a significant way, the public's trust in the profession is undermined. The Tribunal considered that public confidence in the profession would be seriously damaged if a finding of impairment were not made in this case and neither would it promote proper professional standards and conduct for members of the medical profession.

156. In the circumstances, the Tribunal concluded that a finding that Dr Weledji's Fitness to practise remains impaired was necessary to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for members of the profession.

157. Accordingly, the Tribunal determined that Dr Weledji's fitness to practise currently remains impaired by reason of his deficient professional performance.

Determination on Sanction - 04/07/2025

1. Having determined that Dr Weledji's fitness to practise is impaired by reason of deficient professional performance, the Tribunal has to decide in accordance with Rule 22(1)(h) of the Rules what action, if any, it should take with regard to his registration.

The Evidence

2. The Tribunal has taken into account the background to the case and the evidence received during the earlier stage of the hearing where relevant to reaching a decision on what action, if any, it should take with regard to Dr Weledji's registration.

3. Dr Weledji provided a bundle at this stage which included, but was not limited to, certificates for courses he had attended on dates between 2013 to 2025, particularly relating to colorectal surgery; medical articles and publications he was involved in writing as the author or as co-author (in some cases as surgeon), poster presentation confirming his speaking at national and international conferences such as European Colorectal Congress 2023; and a video of his participation in the Isbert ESCP Proctology Operative Skills course on 22 September 2015. Dr Weledji also gave oral evidence at this stage.

Submissions

<u>On behalf of the GMC</u>

4. Mr Terence Rigby, counsel, submitted that the appropriate sanction is erasure, although he acknowledged that the question of appropriate sanction is a matter for the Tribunal exercising its own independent judgement. Mr Rigby referred the Tribunal to relevant paragraphs of the Sanctions Guidance (February 2024 version) (the SG), in particular, paragraphs 45 and 46, submitting that it had now been some twenty-four years since concerns about the doctor's performance had been raised, and added, that even as of today, there is no independent objective evidence of his clinical performance as a surgeon. Mr Rigby submitted that Dr Weledji has failed to produce evidence of insight and of remediation.

5. Mr Rigby drew the Tribunal's attention to paragraphs 163 and 168 of the SG which deal with matters relevant at a review hearing. He added that as found by the Performance Assessment (PA) Team, Dr Weledji's clinical practice would place patients at risk. He reminded the Tribunal of the options available to it at this review hearing when considering the appropriate sanction. Mr Rigby submitted that there is nothing positive that would result from a further period of suspension or a period of conditional registration. Mr Rigby acknowledged Dr Weledji's submission in his evidence that he would have in place supervision and mentoring from a colleague in the UK and improve his skills as a surgeon but there was no evidence from that individual to support Dr Weledji's assertion.

6. Mr Rigby drew the Tribunal's attention to paragraphs 101 and 103 of its determination on impairment. He submitted that Dr Weledji has not provided any evidence of insight or remediation, nor any evidence that he is fit to practise. He reminded the Tribunal of the results of the most recent PA where the PA team found Dr Weledji's performance to be deficient in several categories and concluded that he presented a risk to patients.

7. Mr Rigby submitted that there is underlying evidence to suggest that Dr Weledji does not accept what the PA team have found about his clinical practice and skills, and as a clinical surgeon carrying out operations on patients. This he submitted again demonstrated Dr Weledji's lack of insight into the concerns raised and his failure to demonstrate evidence of remediation of the issues in question, namely his clinical practice as a surgeon carrying out operations on patients, and not his practice as an academic or as a lecturer.

8. Mr Rigby acknowledged the bundle provided by Dr Weledji for this stage of the proceedings contained some useful evidence that he was the author or co-author of a collection of articles and publications. However, Mr Rigby submitted that the publications did not demonstrate Dr Weledji's clinical practice and skills. Further, Mr Rigby submitted that in relation to the courses Dr Weledji had attended, there is no evidence of his learning from these courses.

9. Mr Rigby went on to say that Dr Weledji has demonstrated the same lack of insight into the concerns as he did at the previous hearings and he has not undertaken any remediation. He said that the GMC submits firstly that on the findings of the Tribunal, as above, Dr Weledji's performance was rightly assessed as being deficient and his restoration to practise as being unsafe to potential patients; secondly that Dr Weledji was found to lack insight into his deficiencies as on previous hearings and has a wholly misguided belief that his academic status is sufficient to demonstrate that he is safe to carry out surgery in the UK which again showed his lack of insight; and then thirdly, there was no evidence that Dr Weledji has taken any steps over the past twenty-four years to remediate his deficiencies as a surgeon.

10. Mr Rigby submitted that, bearing in mind Dr Weledji's entrenched lack of insight as to his deficient professional performance and his lack of remediation over such a long period, and the continuing impairment of his fitness to practise as found by this Tribunal, Dr Weledji's name should be erased from the medical register. He submitted that this is the only proportionate sanction to protect and promote the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for the members of the profession.

11. Mr Rigby invited the Tribunal to erase Dr Weledji's name from the medical register.

Dr Weledji

12. Dr Weledji reminded the Tribunal that he had full registration with the GMC as a surgeon. He said he went through the SHO training to gain the full registration and that therefore he must have met the requirements to practise as a safe doctor. He said that the GMC had failed to identify the root cause of the problem which led to the concerns about his clinical performance, namely, that whilst working as a locum surgeon, and performing a haemorrhoidectomy procedure, he had asked for assistance from a senior colleague in treating a bleeding complication from a haemorrhoidectomy. Dr Weledji explained that that was his first such procedure and that as a trainee doctor, it was right for him to have asked for assistance.

13. Dr Weledji said that his work in Cameroon, which spanned over several years from 2013 up to 2025, had not been recognised by the GMC. Dr Weledji accepted that he had not provided any objective evidence relating to his clinical practice, but submitted however, that the best evidence is documented scientific evidence. He said that if required, he could obtain the necessary evidence to support his assertions about his clinical skills. Dr Weledji submitted that in terms of his insight as to the lack of clinical skills or knowledge, he has continued to participate actively in continuing medical education as illustrated by the workshops and courses he had attended.

14. In relation to the PA, Dr Weledji submitted that this took place over one day and was therefore not adequate to properly assess his medical knowledge and skills. He told the Tribunal that for the International Associations of Coloproctology to invite him to their workshops and to their meetings, it must demonstrate that he has enough credibility and added that the GMC cannot ignore that. He told the Tribunal of the various awards he had achieved in his clinical work, including the Ronald Raven Fellowship from the British Association of Surgical Oncology.

15. Dr Weledji submitted that erasing his name from the medical register would be drastic and disproportionate. Dr Weledji said that the concerns in this case were not equivalent to misconduct matters. He said his performance as a clinician had not been assessed properly and he should be given the opportunity to work in a hospital environment under supervision to show that he could work as a safe clinician, and that would allow him to provide objective evidence of his clinical skills.

16. Dr Weledji submitted that he did not have the benefit of the opportunities available to a doctor in the UK and that he had used his own resources to complete his training and improve his medical knowledge and skills. Dr Weledji submitted that if given the opportunity to work as a doctor in the UK, he could show that he was able to practise as a safe doctor and his work would be of benefit to surgery, to science, and to teaching young doctors.

17. Dr Weledji submitted that he had insight into the concerns and that is the reason why he continued to educate himself. He added that when working in the UK, he was never

attached to a Deanery and had obtained his fellowship purely by the work he had done himself.

18. Dr Weledji submitted that his name should not be erased from the medical register.

The Relevant Legal Principles

19. The Tribunal accepted the advice of the legal qualified chair.

20. The decision as to the appropriate sanction to impose, if any, in this case was a matter for this Tribunal exercising its own judgement.

21. In reaching its decision, the Tribunal took account of the SG. It had borne in mind that the purpose of sanctions was not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

22. Throughout its deliberations the Tribunal applied the principle of proportionality, balancing Dr Weledji's interests with the public interest. It reminded itself that it should only impose the minimum sanction necessary to achieve the statutory overarching objective. In deciding what sanction, if any, to impose the Tribunal considered each of the sanctions available, starting with the least restrictive. The Tribunal members were also directed to MPTS Guidance on review hearings, paragraphs 163 - 168 of the SG and a number of decided cases dealing with the approach that Tribunals should take at review hearings.

23. Paragraph 168 of the SG as amended by section 35D (5) of the Medical Act 1983 provides:

> "Where a doctor's registration is suspended, the tribunal may direct that
>
> a) the current period of suspension is extended (up to 12 months)
> b) the doctor's name is erased from the medical register (except in cases that relate solely to the doctor's health and/or knowledge of English)
> c) impose a period of conditions (up to three years).

24. The Tribunal was directed that it would be wrong to equate maintenance of innocence with a lack of insight. However, continued denial of the misconduct found proved will be relevant to the Tribunal's considerations on review. Cases of *Sawati v GMC [2022] EWHC 283 (Admin)* and *Yusuff v GMC [2018] EWHC 13 (Admin)* and *Amao v Nursing and Midwifery Council [2014] EWHC 147*,

a. The findings of fact are not to be reopened;
b. The registrant is entitled not to accept the findings of the Tribunal;

c. In the alternative, the registrant is entitled to say that he accepts the findings in the sense that he does not seek to go behind them while still maintaining a denial of the conduct underpinning the findings;
d. When considering whether fitness to practise remains impaired, it is relevant for the Tribunal to know whether or not the registrant now admits the misconduct;
e. Admitting the misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it;
f. If it is made apparent that the registrant does not accept the truth of the findings, questioning should not focus on the denials and the previous findings;

A want of candour and/or continued dishonesty at the review hearing may be a relevant consideration in looking at impairment.

The reviewing tribunal has no power to reopen or 'go behind' previous findings of fact on professional misconduct; it should take them into account and rely on them. If a practitioner seeks to disturb the findings of fact at the original hearing as 'unsound' and introduce fresh evidence in support of this, they must apply to the high court to admit this fresh evidence on appeal. *Myhill v General Medical Council [2025] EWHC 474 (Admin)*.

Section 35D of the Act sets out the powers available to an MPT at a review hearing. Tribunals should make clear in their determination what direction they are making and refer to the guidance Taking effect of directions – new & review hearings, to ensure they are clear which specific power they are exercising, to establish what date the new direction will take effect and what sanction will be in place during the appeal period to ensure that their directions align with their intentions.

As Lord Hope of Craighead observed in *Marinovich v GMC [2002] UKPC 36, at [28]*, an MPT:

> "is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the [MPT] in the light of its experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession".

The procedure to be adopted on a review is set out in Rule 22 of the GMC Fitness to Practice Rules 2014. In *Abrahaem v GMC [2008] EWHC 183 (Admin)*, Blake J described the procedure as "an ordered sequence of decision making". The Tribunal must first address whether fitness to practise is impaired before considering further sanction. In doing so:

"the review has to consider whether all the concerns raised in the original finding of impairment through misconduct have been sufficiently addressed to the Tribunal's satisfaction. In practical terms there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments."

The Tribunal's Determination

25. The Tribunal considered the LQC's advice, and the submissions made by both parties. It reminded itself of its findings at the impairment stage and noted all of the evidence it had received.

26. As this is a review hearing, the Tribunal had regard to the relevant legal framework as set out in Section 35(D) of the Medical Act 1983, as amended, and Rule 22 of the Rules, and accordingly first considered whether this case could be concluded with a period of conditions.

Conditions

27. The Tribunal account of paragraphs 81 – 85 of the SG, and determined that paragraphs 81 (b) and (c), 82 (a), (b), (c) and (d), 84 (a), (b) and (c), and 85 are engaged. These state:

'81 Conditions might be most appropriate in cases:

a ….
b involving issues around the doctor's performance
c where there is evidence of shortcomings in a specific area or areas of the doctor's practice
d ….

82 Conditions are likely to be workable where:

a the doctor has insight
b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
c the tribunal is satisfied the doctor will comply with them
d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised.

84 Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:

a no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage
b identifiable areas of their practice are in need of assessment or retraining
c willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting patient safety …

85 Conditions should be appropriate, proportionate, workable and measurable.'

28. The Tribunal was mindful of the findings of deficient professional performance that led to Dr Weledji's suspension in 2001, and the subsequent findings made since. It reminded itself of the findings made by the PA team following the assessment undertaken in 2001. The assessors opined that Dr Weledji should not continue as a practising surgeon and they recommended that he should limit his professional practice and retrain in a non-surgical field, and that his retraining should address his inability to perceive that he had limitations to his professional performance.

29. In their report, prepared following the PA in September 2024, the PA team found serious and persistent errors in Dr Weledji's practice across multiple assessment categories. The team found that his **open surgical skills were unsafe**. Dr Weledji's laparoscopic skills were also unsafe, but the team noted that Dr Weledji had insight into this aspect of his performance. Further, it found evidence of **unacceptable performance** in the categories of Assessment of Patients' Condition, Clinical Management, Operative/Technical Skills, Relationships with Patients and Working with Colleagues. The team stated that there were multiple instances within each of these categories where it concluded that **Dr Weledji's performance put patients at jeopardy.** The combination of failings interacted in an adverse way, for example, ineffective clinical reasoning leading to ineffective history taking. The team noted that Dr Weledji's knowledge assessment was below average when tested and that **he showed no good insight when asked to reflect on aspects of his performance**. **(Emphasis added)**

30. Dr Weledji lacked insight into the concerns about his clinical skills and did not consider that he was unfit to practise safely. There was no objective evidence before the Tribunal that Dr Weledji would be willing to retrain and be supervised. It was not satisfied that Dr Weledji would comply with any conditions imposed. The Tribunal reminded itself of the findings of the 2024 PA team. The PA team found that Dr Weledji was very reluctant to accept any criticism of his work.

31. Furthermore, the Tribunal was of the view that bearing in mind Dr Weledji's attitude to the concerns identified by the PA conducted in September 2024 and previously, he would not respond positively to remediation or supervision.

32. The Tribunal was mindful that, based on the findings and recommendations made by the PA team, the level at which Dr Weledji would be able to work would essentially equate to below registrar level. The Tribunal was concerned that given Dr Weledji's current seniority in his role as a colorectal consultant surgeon, which included him undertaking a teaching role of junior colleagues, and his status as a professor of surgery, it was highly unlikely that he would be able to adjust well in a role which required him to be directly and constantly supervised.

33. The Tribunal was of the view that none of the factors listed above to indicate that conditions would be workable applied in this case. In the circumstances, the Tribunal concluded that conditions would not be appropriate, practical or workable. Furthermore, given the seriousness of its findings, as set out in its determination on impairment, conditions would not be sufficient to protect, promote and maintain the health, safety and well-being of the public, promote or maintain either public confidence in the medical profession or proper professional standards and conduct for members of the medical profession. Therefore, the Tribunal determined that imposing a period of conditional registration would not be appropriate in this case.

Suspension

34. The Tribunal then considered whether the case could be concluded with a period of suspension. It was mindful that Dr Weledji's registration with the GMC has been subject to an indefinite suspension since June 2004.

35. The Tribunal had regard to paragraphs 91 – 97 of the SG. The Tribunal noted that suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and the public about what is regarded as acceptable or unacceptable. It can also have 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.

36. Paragraph 94 states:

> *"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".*

37. In considering whether suspension was appropriate, the Tribunal also considered Paragraph 97 to be engaged and in particular sub paragraphs (b), (e) and (g) which state:

"Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate

' *….*

b *In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.*

….

e *No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.*

….

g *The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.'*

38. The Tribunal determined that none of the factors in favour of suspension outlined above in paragraph 97 applied in Dr Weledji's case. It took into account that it has been some twenty plus years between the first PA in 2001 and the second PA in 2024. Whilst the categories in which Dr Weledji might have been assessed may be different in September 2024, primarily the concerns about his clinical practise and skills remained the same.

39. In the 2024 PA, Dr Weledji was assessed as a Consultant General Surgeon and he failed to reach an acceptable standard in five out of the seven categories that he was assessed in. His performance was mostly unacceptable, and the assessors considered his surgical skills were unsafe. They also found serious and persistent errors in Dr Weledji's practice across multiple categories which resulted in patients being put at risk.

40. The Tribunal found that Dr Weledji has demonstrated a persistent lack of insight. During his evidence to the Tribunal, Dr Weledji largely maintained that his clinical skills were adequate for him to continue to practise as a consultant. Rather than accepting the findings of the 2001 and 2024 PAs, Dr Weledji described their findings as a conspiracy against him and criticised the PA teams for their handling of those assessments. Dr Weledji repeatedly challenged the findings of the 2024 PA team and questioned their impartiality in carrying their role as independent assessors. He sought to deflect any failures away from himself. The Tribunal had considered all the complaints made about the assessment process by Dr Weledji at the impairment stage and did not find them to be substantiated.

41. Dr Weledji relied upon his written work and produced numerous articles and publications, particularly in relation to colorectal surgery, to demonstrate his clinical competence. It was his view that these published articles relating to this area of his work

were sufficient to demonstrate that he had the necessary clinical skills to practise safely. There was some evidence that he accepted that his clinical skills might not be up to the UK standard now required. In this regard, he acknowledged that, if allowed to return to practise medicine in the UK, he would need some level of supervision. Dr Weledji told the Tribunal that a Professor at Kings College would be able to provide that supervisory and mentoring role, however, the Tribunal received no objective evidence, such as a letter or testimonial from the Professor, to support Dr Weledji's assertion. Furthermore, the Tribunal had received no independent evidence, testimonials or references to contradict the findings made in the PA that Dr Weledji's clinical skills would pose a risk to patient safety.

42. The Tribunal noted the bundle of certificates of participation at courses Dr Weledji attended or completed, in relation to his field of clinical practice, as well as a video recorded during his attendance at a practical course. At the end of the video Dr Weledji is interviewed about his views on the course and its benefits. The Tribunal was concerned, however, that beyond this, it had not been provided with any evaluation of Dr Weledji's attendance at the courses, there was no independent objective evidence to demonstrate Dr Weledji's learning from these courses, nor how any learning had been incorporated into his clinical practice. Further, there was no evidence of any targeted learning to address the concerns about his relationship with patients and colleagues and about his broader clinical and interpersonal skills that had been raised specifically by the PA team in their report.

43. Throughout his evidence, Dr Weledji has demonstrated a lack of understanding of the seriousness of the concerns raised about his clinical practice, and the shortcomings identified by the PA team in respect of his clinical skills. He has not provided any evidence to show what steps, if any, he had taken to address the concerns.

44. No testimonials or references were provided by Dr Weledji relating to his clinical practice in Cameroon, apart from the documents referred to at the impairment stage, which had very little content.

45. The Tribunal has not been provided with any evidence for it to be satisfied that Dr Weledji had any insight into the concerns about his clinical practice. To the contrary, he has demonstrated a persistent lack of insight. The Tribunal has not been provided with any objective evidence to satisfy it that a period of retraining and/or supervision is likely to be appropriate.

46. The Tribunal concluded that due to Dr Weledji's entrenched view that he does not have the deficiencies identified, he is unwilling or unable to remediate those issues and this creates a significant risk of repetition.

47. In Dr Weledji's case, there is evidence before the Tribunal that demonstrates that suspension is unlikely to be successful because of his unwillingness to engage in appropriate remediation.

48. The Tribunal was mindful that since making his application to the GMC in September 2023 for his registration to be restored, Dr Weledji has not taken the opportunity to undertake any remediation, such as in the form of targeted learning and relevant and evaluated training courses, to satisfy it that he did not present a risk to patient safety. The Tribunal could not be satisfied that Dr Weledji's return to unrestricted clinical practice would not put patient safety at risk. In the Tribunal's view, there is a serious risk that patients may come to harm should Dr Weledji be allowed to practise medicine in the UK.

49. The Tribunal bore in mind the public interest in maintaining doctors on the register. However, the Tribunal concluded that a sanction of suspension would be inappropriate and insufficient to mark the seriousness with which it viewed the concerns raised about Dr Weledji's clinical performance, and the lack of insight he has demonstrated over the past twenty years. The Tribunal was of the view that it was fundamental to public trust in the profession that doctors should be able to meet the standards expected of them by the UK regulator, and particularly where this involved surgical procedures.

50. As Dr Weledji has already been subject to an indefinite suspension for some time, the Tribunal concluded that a further period of suspension would not serve any useful purpose. The reason for this was because Dr Weledji has not been able to demonstrate any evidence of insight and neither has he taken steps to address the concerns.

51. In all the circumstances, the Tribunal determined that suspension would not be appropriate to uphold the statutory overarching objective, which is to: protect, promote and maintain the health, safety and well-being of the public; promote and maintain public confidence in the profession, and promote and maintain proper professional standards and conduct for members of that profession.

Erasure

52. The Tribunal went on to consider whether the sanction of erasure was appropriate and proportionate in this case and took into account the guidance in the SG. The Tribunal reminded itself again of its findings at the impairment stage of these proceedings.

53. The Tribunal considered paragraphs 107 and 109.

Paragraph 107 states:

"The Tribunal may erase a doctor from the medical register in any case -except one tha relates solely to the doctor's health and/or knowledge of English- where this is the only means of protecting the public".

Paragraph 109 states:

"Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive):

a *A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate*

….

j *Persistent lack of insight into the seriousness of their actions or the consequences..'*

54. In his evidence, Dr Weledji spoke of the matters before this Tribunal stating that to erase his name from the medical register would be drastic. He said that it was not as if this was a case involving misconduct but simply was one about his performance for which he had provided an explanation. He regarded the concerns about his deficient clinical performance as being less serious than a case about misconduct. Dr Weledji expressed the view that the level of his academic work and published articles alone should be sufficient to show that his clinical skills are adequate to meet the required standard for a consultant surgeon.

55. The Tribunal was concerned by Dr Weledji's attitude. His attitude towards the findings of the two PAs suggested a degree of arrogance, and it noted that he was unwilling to accept or to properly engage with the findings made about the deficiencies in his professional performance. He has sought to dismiss any evidence which goes to support the concerns identified, labelling it as a conspiracy against him, or a misunderstanding. He maintained at the sanction stage his expressed view that the performance assessors simply wished to "maintain the status quo". The Tribunal considered Dr Weledji's lack of insight, spanning over a very long period, to be entrenched and his minimising the seriousness of this case to be of significant concern.

56. The Tribunal has taken account of its findings, as set out above, in determining that conditional registration or a further period of suspension are not the appropriate sanction. The Tribunal reminded itself of the need to act in a proportionate manner in imposing sanctions. The Tribunal determined that a sanction of erasure is necessary in Dr Weledji's case in order to adequately protect the public and is therefore the minimum action required to do so. The Tribunal recognises that this may lead to some difficulties for Dr Weledji but it considered in all the circumstances of this case that erasure is necessary to meet the legal duty to protect the public.

57. The Tribunal took into account the impact that this sanction will have upon Dr Weledji. However, in all the circumstances, the Tribunal concluded that his interests are outweighed by the need to protect and promote the health, safety and wellbeing of the public, promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for the members of the profession.

58. Based on the evidence before it, the Tribunal considered that Dr Weledji's mindset about his clinical abilities to undertake clinical practice, and the risks he presents to patients if allowed to return to clinical practice, is unlikely to change.

59. The Tribunal considered that a member of the public would be concerned if a direction was not made for erasure in a case where there were such serious concerns about a consultant surgeon's clinical professional skills.

60. The Tribunal reminded itself of the findings made at the impairment stage. Dr Weledji's performance was rightly assessed as being deficient and his restoration to practise as being unsafe to potential patients. Dr Weledji lacks insight into his deficiencies and that has been shown at every hearing from 2001 to 2025. He has a wholly misguided belief that his academic status and reputation as shown by an extensive and impressive body of published medical articles are sufficient in themselves to demonstrate that he is safe to carry out surgery in the UK. The Tribunal determined he lacks insight. There is no evidence before the Tribunal to show that he has taken any steps or any adequate steps to address his deficiencies as a surgeon. There is no evidence before the Tribunal to show that he has taken any steps or any adequate steps to address wider concerns raised in the PA that was carried out in 2024. Were he to be allowed to resume unrestricted practice as a Surgeon in the UK, he would undoubtedly present a risk to patient safety.

61. It concluded that the only proportionate sanction is the sanction of erasure:

(a) To protect and promote the health, safety and wellbeing of the public.
(b) To promote and maintain public confidence in the medical profession.
(c) To promote and maintain proper professional standards and conduct for the members of the profession

62. For these reasons, the Tribunal directs that Dr Weledji's name is erased from the medical register, as set out in paragraph 168 (b) of the SG, as amended by Section 35(D) of the medical Act 1983.

63. The Tribunal noted that Dr Weledji's registration is currently suspended indefinitely. In the circumstances, the substantive direction of erasure will take effect 28 days from the date on which written notification of this decision is deemed to have been served, unless he appeals in the interim. If he does appeal, the suspension currently in place will remain in force until the appeal has concluded.

64. That concludes the case.