Primary Health Lists

The Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care) Rules 2008

IN THE MATTER OF THE NATIONAL HEALTH SERVICE (PERFORMERS LISTS) (WALES) REGULATIONS 2013

[2017] 3209.PHL

Heard at Port Talbot Civil Justice Centre
19, 20, 21 and 22 June 2018

BEFORE
Ms Siobhan Goodrich (Judge)
Dr Parvinder Garcha (Specialist Member)
Ms Jane Everitt (Specialist Member)

BETWEEN:

DR JOHN CLAYSON BEVAN

APPELLANT

and

NHS WALES

RESPONDENT

Representation
For the Appellant: Mr Brian Cawsey, Counsel, instructed by Peter Lynn and Partners
For the Respondent: Mr David Story, Counsel, instructed by NWSSP Legal and Risk Services.

DECISION AND REASONS

The Appeal

1. Dr Bevan appeals against the decision to remove his name from the Medical Performers List (the MPL) maintained by the Abertawe Bro Morgannwyg Health Board (the Board"). The decision made under paragraphs 12 (3) (c) and 10 (3) and (4) (a) of the National Health Service (Performers' List) (Wales) Regulations 2004 ("the Regulations") was that the continued inclusion of Dr Bevan's name in the Medical Performers' List (MPL) would be prejudicial to the efficiency of the

services that those in the relevant list perform.

The Chronology and Background

2. There is a long and complex history of regulatory action. We set out below the main events from the agreed chronology:

    a. Dr Bevan qualified as a doctor at the University of Wales in 1976. He began work as a GP at the Cockett Surgery, Swansea in 1981.

    b. In 2007 a routine Quality and Outcomes Framework (QOF) visit raised concerns over: the management of controlled drugs; exception reporting; management of chronic conditions; recording of information. Dr Bevan agreed to undergo assessment by the National Clinical Assessment Service (NCAS).

    c. On 10 October 2008, following the NCAS report, Dr Bevan was suspended by the Board who considered that his practice presented a risk to patients.

    d. On 9 January 2009 suspension was varied to contingent removal to allow Dr Bevan a period of re-training in an Advance Training Practice (ATP).

    e. A subsequent panel was convened to consider two alleged breaches of conditions. The case was referred to the GMC and Dr Bevan was also suspended from the MPL. In November 2009 the MPL suspension was revoked and 18 conditions were imposed (i.e. under contingent removal powers).

    f. In 2010 the GMC asked Dr Bevan to undergo a performance assessment. The outcome in 2011 as relevant to the domains was:
        - Maintaining professional Performance – cause for concern
        - Assessment of Patient's condition – unacceptable
        - Record Keeping – unacceptable.

    g. On 19 March 2012 the Interim Orders Panel (IOP) of the GMC imposed conditions. These were subsequently the subject of signed undertakings given by Dr Bevan to the GMC.

    h. On 5 September 2012 the LHB agreed to vary conditions so as to mirror the undertakings in the GMC proceedings.

    i. MPL conditions were subsequently reviewed in 2013 and 2014.

    j. On 11 February 2015 some 14 conditions were imposed by the

Board (see C211). These included supervision of Dr Bevan's day to day work by a GP supervisor.

k. Supervision was provided by Dr Bevan's partner, Dr Lloyd. However, he left the practice in September 2015.

l. On 30 March 2016 Assessors appointed by the GMC reported on professional performance of Dr Bevan. The summation of their assessment was:

> *"Domain 1: Knowledge, Skills and Performance*
> *Maintaining Professional Performance* ***Unacceptable*** *(previous Assessment graded a Cause for Concern)*
> *Assessment* ***Unacceptable*** *(no change)*
> *Clinical Management* ***Acceptable*** *(no change)*
> *Operative/Technical Skills* ***No Judgement***
> *Record Keeping* ***Cause for Concern***
> *(previous Assessment graded Unacceptable)*
>
> *Domain 2: Safety and Quality*
> *Safety and Quality* ***No Judgement***
>
> *Domain 3: Communication, Partnership and Teamwork and Domain 4:*
> *Maintaining Trust*
> *Relationships with Patients* ***Acceptable***
> *(previous Assessment graded Unacceptable)*
> *Working with Colleagues* ***Acceptable*** *(no change)"*

The GMC Assessors concluded that:

> "*The Team however do not consider he has progressed sufficiently since his last assessment to work generally. Dr Bevan should not work single handed; having fulfilled this requirement previously he continues to benefit from having a partner within his own practice. He should have clinical supervision and an educational supervisor who should also be the workplace reporter; an educational supervisor should be appointed by the Responsible Officer and Dr Bevan should share this report with his employers. Supervision should include whatever measures are needed to address the concerns of this report, namely Dr Bevan's knowledge of current practice, his assessments of patients, and his record keeping."*

m. Dr Werner became a partner after Dr Lloyd had left the practice, but he resigned in December 2016.

n. Dr Bevan signed revised GMC undertakings on 29th November 2016. The key elements were that he had taken a partner (Dr Caroline Shreeve) in the practice, he had secured a work place reporter (his practice nurse, Sharon Delve), a clinical supervisor (Dr Anjula Mehta), and an educational supervisor (Dr Gerry O'Dwyer). He also had to provide a personal development plan

by 29th December 2016.

o. On 12 December 2016 Dr Shreeve was appointed by Dr Bevan as a partner. She has never worked in the practice. (Her application to join the MPL was rejected and is the subject of an ongoing appeal).

p. In January 2017 Dr Mehta began clinical supervision sessions with Dr Bevan.

q. On 6 April 2017 Dr Bevan was given a grace period of three months to actively resolve the situation by finding another partner. A structured timetable regarding steps to be taken regarding the recruitment of a new partner was agreed with Dr Bevan. This included that he would consider whether taking up a partnership or salaried GP status in a practice, possibly a merged practice, might allow him to continue practising.

r. On 30 June 2017 the Board decided to vary conditions so as to bring them into line with the GMC undertakings. The revised conditions included:

"Condition 8
You must design a Personal Development Plan (PDP), with the Educational Supervisor and approved by the Responsible Officer (or their nominated deputy), with specific aims to address the deficiencies in the following areas of practice:

i. Maintaining professional performance
ii. Assessment of patient's condition
iii. Record keeping

Ongoing three monthly meetings between you and the Educational Supervisor should take place during which the PDP, any progress made and any issues arising from the reports of the meetings with the Clinical Supervisor are discussed. The ABMUHB will require either minutes of these meetings or a structured report within a week of such meetings."

and

"Condition 11.
You must only work in a group practice setting where there are at least two practising GP partners (including yourself). The GP who is in partnership with you should be doing enough clinical sessions within your practice to offer satisfactory assurance to the Responsible Officer that not only is there an element of support for you but will lead the clinical governance in the practice."

s. On 2 October 2017 the GMC informed the respondent that Dr Bevan had been asked to stop working immediately until the

situation with his partner (Dr Shreeve) had been rectified. The GMC stated that they were currently deciding what, if any, further action needed to be undertaken."

The Board's Decision

3. A reference panel meeting was convened on behalf of the Board and was held on 13 November 2017. It was chaired by Ms Dover. The meeting was attended by Dr Bevan and his representative from the Medical Defence Union. The reference panel found that Dr Bevan was in breach of Conditions 8 and 11. It decided also to remove Dr Bevan on efficiency grounds. The reasons for the decision were essentially that:
   "no evidence of educational supervision has been provided to Abertawe Bro Morgannwg University Health Board and you are not working within a group practice setting where there are a minimum of two GPs (including yourself). There continues to be concerns about the safety of clinical practice and your lack of insight into the areas of concern. There has also been demonstrated a lack of meaningful engagement in remediation."

The Notice of Appeal

4. In this Dr Bevan maintains that the decision was unfair and disproportionate. The panel failed to adequately consider the circumstances explaining why the two conditions had not been met. The decision means the end of his career. He asked that the decision be set aside.

The Parties' Respective Positions

5. In a nutshell:
   a) The respondent's case is that the decision to remove Dr Bevan from the MPL was justified on the basis of his breaching of conditions and ongoing concerns about the safety of his practice.
   b) The appellant's position is that the decision made by the respondent to remove him from the MPL was wrong. Any matters prior to the decision to suspend and remove from the MPL should be disregarded. As to the conditions, the respondent relied too heavily on the fact that one education supervisor's report was provided approximately one week late. As to Condition 11, the respondent consented to his working as a sole practitioner until his suspension and Dr Roeves' statement showed Dr Bevan's efforts to comply with the condition imposed. The respondent relied too heavily on the evidence of Dr Mehta who has far less experience of the appellant's knowledge, ability and practices than Dr Lloyd and Dr O'Dwyer. He denies ever prejudicing patient safety as alleged by Dr Mehta. The respondent could and should have

either varied the conditions imposed or imposed new conditions to take into account his experience, the known difficulties in recruiting GPs in Wales and the effect his removal from the MPL would have on his patients and other surgeries in the area.

The Documents

6. We received a paginated and indexed bundle. In the course of the hearing we agreed to receive various further documentation provided by the appellant which was then provided in an indexed bundle. At the outset of the hearing Ms Cawsey agreed that the stance taken in the skeleton (which he did not write) that past history was irrelevant, was misplaced given that Regulation 11 (6) and (7) require the tribunal to consider the overall effects of previous incidents.

The Hearing

7. It was agreed by both parties that the nature of the appeal is by way of redetermination**:** it is open to the tribunal in its redetermination to make any decision that would have been available to the board. Our task is not that of review of the panel decision but to make our own in the light of the evidence before us which includes evidence available as at the date of the appeal hearing.

8. At the outset of the hearing Mr Cawsey informed the tribunal that Dr Bevan's position regarding condition 11 was that this was explained by the difficulties that he had had recruiting a GP partner. Ultimately, Dr Bevan was inviting the tribunal to vary the conditions so as to suspend his name on the MPL until such time as he had had the opportunity to find a GP partner. He said that a recent and promising line of enquiry had developed regarding a new partner but that if this did not materialise it was recognised that this would be the end of the line. The judge, noting that there was no evidence regarding this potential applicant, asked Mr Cawsey whether he was seeking an adjournment in order to pursue the potential appointment of a partner. Mr Cawsey said that, if it was realistic to do so, he would make that application in due course.

The Evidence

9. We heard oral evidence on behalf of the respondent from: Dr Anjula Mehta (GP and Clinical Director): Dr Roeves, (GP and Unit Medical Director): Ms Hilary Dover, ((Director of Primary care and Community Services); and Ms Sharon Miller (Head of Primary Care). We heard evidence from Dr Bevan over two days as well as evidence from Dr O'Dwyer who, in addition to his involvement when Dr Bevan was subject to retraining in the ATP, had acted as his educational supervisor since about late 2016. We also received written evidence on behalf of the appellant from: Dr Bevan's former partner, Dr Lloyd; Ms Delve, the practice nurse; and a patient, Mr Evans.

10. It is unnecessary to summarise the main evidence of the witnesses since this is set out in their statements which stood as their evidence in chief. When making our findings we will refer to the key aspects of the oral evidence before us.

The Burden and Standard of Proof

11. We directed ourselves that the respondent bears the burden of establishing that Dr Bevan's name should be removed from the List. It is common ground that any facts in issue should be determined by applying the civil standard of proof. Ultimately the issue of whether Dr Bevan should be removed from the list is a matter for our judgement in the light of our assessment of the facts and the risks, if any, posed by his practice.

Submissions

12. We do not attempt to set out each and every matter upon which the parties relied. At the end of the oral evidence the key features of the respective positions of the parties may be summarised as set out below:

13. Mr Story submitted by way of overview that:
    a) The Board's decision should be upheld. Dr Bevan had been in breach of condition 8 and 11. The evidence suggested that he had no intention or ability to remediate his practice. It was not efficient to continue to support Dr Bevan. Although the decision was based on inefficiency Dr Bevan has shown himself to be unsuitable in any event.
    b) The respondent's witnesses were highly credible. By way of contrast Dr Bevan was highly inconsistent in his evidence. He seemed to accept criticism but then refuted it. His evidence lacked credibility in some respects. One example was his evidence regarding the GP application. It was not credible that he had neglected to mention until today that he had spoken to the applicant. Dr O'Dwyer's evidence was highly partisan. He had signed a witness statement as true but, in reality, had no idea as to the truth of some of its contents. His opinion was influenced by his belief that local health boards have it in for those on the lists. The evidence of Dr Mehta and Dr Roeves should be preferred.
    c) The key issues were:
        i) The deficiencies in Dr Bevan's practice,
        ii) Failure to progress
        iii) Lack of insight.

        As to i), there were a number of examples of poor clinical practice which include the prednisolone case, the mental health assessments and the bite case. Dr Bevan seeks to

downplay them as minor errors. He did not appreciate that matters such as mental health assessment and failure to report a notifiable disease are very serious. His attitude generally was that his practice was acceptable because no harm had occurred. In cross examination he came to accept almost all of the criticisms but then rowed back on that subsequently.

As to ii) there had been no progress over an extended period of time. Record keeping was a cause for concern in the NCAS report in 2007 and remains a concern. The concerns during the GMC assessment in 2011 have stayed the same in 2016. There has been no progress under the supervision of Dr Mehta. The case based discussions concerning mental health cases in early January, late January and August 2017 show that the same points arose. Although Dr Bevan said in supervision that he understood the criticism he failed to take it on board. Even now he has not managed to progress his understanding. His attitude is that his actions did not result in harm. The paediatric cases show the absence of sustained development.

As to iii), the fact that Dr Bevan failed to report Dr Mehta's concerns about his ability to engage with reflective practice to Dr O'Dwyer showed his lack of insight. It is a clear sign that he lacks willingness to learn. Further, he refused to accept before the Board that he had made any mistakes despite having made concessions about mistakes within supervision. He had reinforced his position in evidence and it had taken significant pressure in cross examination for him to agree that he had made any mistakes. The whooping cough case seemed to be new information to Dr Bevan despite the fact that he had heard Dr Mehta give evidence about it the day before.

d) As to the breaches of conditions:
    i) Dr Bevan had made no serious attempt to comply with condition 11. It is an admitted breach. He did not take up other options to practice because it did not suit him. His evidence about the advertisement was frankly bizarre. There is no substantial evidence that a partner will be recruited and, even taking the appellant's evidence at its highest, this does not assist him.
    ii) As to condition 8, this has been framed as the failure to provide reports re the educational supervision report (ESR) from September 2017. An additional matter became apparent on the oral evidence: Dr Bevan did not provide relevant information to his educational supervisor about Dr Mehta's concerns. Dr Bevan has still not provided the ESR. He said in evidence that he may have sent it to Professor Laing but there was no

documentary evidence of this. The evidence showed that Dr Bevan was reluctant to engage with the process.

14. Mr Cawsey submitted that:

a) The tribunal needed to decide if there were sufficient concerns that presented an increased risk. Even if the panel found that there are risks, they are not irremediable. Dr Bevan has demonstrated insight regarding the relevant domains. He can engage and it was ultimately efficient to use NHS resources towards his rehabilitation.

b) There were many positive aspects regarding his efforts to address issues of concern – see C213, C230, 237, 242, 248. Although it was accepted, by and large, the evidence contained damaging reflections on Dr Bevan's clinical practice, there are some nuggets which demonstrate his ability to remedy his defects. There was evidence that he does possess fundamental skills. C69 showed his honesty in admitting his omission of negative findings. C70 showed that he was told to familiarise himself with the chaperone guidance and later did so. C99 showed that he admitted his limitations, for example, regarding the assessment of a patient who had suffered sexual abuse. There were positive features at C69. C87 showed that that the medical record was coherent and comprehensible. There was sufficient evidence to give "the crumb of comfort" that Dr Bevan possessed the skills necessary to develop going forward. He has undertaken the Safeguarding course. At C98 there was some positive feedback amidst critical feedback.

c) In answer to a question from the judge concerning Dr Bevan's engagement with Dr Mehta, Mr Cawsey submitted that the effect of Dr Bevan's evidence was he felt he had no option but to agree with the clinical supervision criticisms in order to meet the conditions. It appeared that there was a personality clash and Dr Bevan had said that he felt vulnerable. In some cases Dr Bevan did demonstrate appropriate clinical standards. The difficulty was that he did not do so consistently but this is a training issue. Some time had been spent considering the prednisolone case and paediatric telephone consultation case. C1152 showed improvement. It was obvious that Dr Bevan has not shown consistent improvement- but he is a doctor who can be rehabilitated.

d) C167 showed that Dr Bevan had clearly struggled to adopt the reflective Gibbs style system but this did not disqualify him from working under conditions. There is an option to train in reflective practice using different tutor methods. It was efficient to allow Dr Bevan the final chance by being trained in reflection.

e) Ultimately, it was the absence of reflective thought and thorough note taking that lie at the very foundation of the

action taken against him. There was evidence of self-awareness, openness, honesty and self-criticism. The starting point should be that whatever means are necessary should be applied. Conditions could be imposed regarding support and supervision. Dr Bevan's position was that he should be supervised at a minimum level (as per the GMC definition) and he did not need close or direct supervision. It was, however, open to the tribunal to impose more onerous conditions.

f) Positive features in Dr Bevan's favour included the fact that the practice list number had been sustained and patients had not left. There was no evidence of any civil claims or complaints. Any failure to follow national guidelines is a training issue. Dr Bevan should be given one last chance.

The National Health Service (Performers List) (Wales) Regulations 2004

15. Regulation 10 (3) provides the Local Health Board with a discretionary power to remove a performer from its medical list where any of the conditions set out in paragraph 10 (4) apply.

(4) The conditions mentioned in paragraph (3) are that the —

(a) continued inclusion of that performer in the Local Health Board's performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case");

(b) ….: or

(c) performer is unsuitable to be included in the performers list ("an unsuitability case").

16. Regulation 11 sets out the criteria for a decision on removal in relation to unsuitability, fraud and efficiency. So far as efficiency cases are concerned Regulation 11 (5) provides that "where a Local Health Board is considering removal of a performer under regulation 10(3) and (4) (a) ("an efficiency case") it shall" consider a number of matters. The key matters in this appeal are the matters referred to in paragraph 5 (c) which we set out in full below:

(6) The matters referred to in paragraph 5(c) are-

a. The nature of any incident which was prejudicial to the efficiency of the services, which the performer performed;

b. the length of time since the last incident occurred and since any investigation into it was concluded;

c. any action taken by any licensing, regulatory or other body, the police or the courts as a result of any such incident;

d. the nature of the incident and whether there is a likely risk to patients;

e. whether the performer has ever failed to comply with a request to undertake an assessment by the NCAA…

f. whether the performer has previously failed to supply information, make a declaration or comply with an undertaking required on inclusion in a list;

g. whether he has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Local Health Board or the equivalent body for such action;...

(7) In making any decision under regulation 10, the Local Health Board shall take into account the overall effect of any relevant incidents and offences relating to the performer of which it is aware, whichever condition it relies on.

(8) When making a decision on any condition in regulation 10(4), the Local Health Board shall state in its decision on which condition it relies.

17. Regulation 12(3) provides:

12(3) If the Local Health Board determine that the performer has failed to comply with a condition, it may decide to-

(a) vary the conditions imposed;

(b) impose new conditions; or

(c) remove the performer from its performers list.

Our Consideration and Findings

18. We have considered all of the evidence before us. If we do not refer to any particular aspect it should not be assumed that we have not taken it into account.

19. We find that the basic history is as set out at paragraph 2 above. We find that there is a very long history of significant concerns held by assessors, independently appointed, regarding Dr Bevan's competence and his ability to carry out adequate assessments of patients' conditions and his record keeping. We place significant weight upon the evidence regarding concerns held by NCAS and the performance assessments undertaken for the GMC in 2011 and 2016. We say this because the full reports, particularly those of the assessors appointed by the GMC demonstrate the meticulous and detailed nature of the individual assessments undertaken in a considered and triangulated manner. The fact is that many of the concerns amply demonstrated in the assessments in 2011 still remained in 2016.

20. We consider that the inadequacies in Dr Bevan's practice as evidenced by the GMC assessors in 2011 and 2016 were wide ranging and went to the very core of the basic skills and attributes required of a general practitioner.

21. The reality is that Dr Bevan has been the subject of contingent removal for many years. The main safety net so far as patient safety is concerned was that, in line with his undertakings to the GMC, he was unable to practice unless supervised by a partner. The efficacy of the contingent removal conditions regarding supervision entirely broke down in December 2016 because no partner was in place. Although Dr Bevan went into partnership with Dr Shreeves she has never worked in the partnership or in the practice. Her application to join the MPL was refused because she was unable to provide the necessary evidence, including satisfactory references, to support her application.

22. We will return to the issue of breach of conditions in due course. In our view the core issue in this appeal is whether the respondent has satisfied us that continued inclusion of Dr Bevan in the MPL would be prejudicial to the efficiency of the services which those included in the relevant performers list perform. Sensibly, and in accordance with the overriding objective, the evidence in the hearing was focussed on eight examples drawn from the case based discussions undertaken in supervision with Dr Mehta (C71, C92, C111, C128, C139, C 173, C172) and the prednisolone case as illustrative of the core issues in this appeal regarding deficiencies in clinical practice, failure to progress and lack of insight.

23. We considered Dr Mehta's evidence and that of Dr Bevan regarding the case-based discussions conducted with him on 18 occasions between 3 January and 12 September 2017. All bar two of these sessions were conducted by Dr Mehta and the balance by her deputy. We noted that some of the CBDs were brought forward by Dr Bevan himself. Further the feedback was recorded and sent to Dr Bevan so that he could seek correction of anything he felt was not fairly recorded or encapsulated in the record of discussion. There is no evidence that Dr Bevan ever raised any concern about the record of his discussions with Dr Mehta.

24. The CBDs when read as a whole identify areas of repeated concern regarding: history taking; the adequacy of clinical assessment; following clinical guidelines; record keeping; the absence of documented safety netting. We do not set out every aspect of each of the eight CBDs but deal with only some aspects in thematic groups.

The Mental Health Cases

25. There were three consultations with different patients.
    a) In the first CBD on 3 January 2017 Dr Bevan felt that his consultation entry captured all relevant information elicited in this consultation. However, he did not enquire regarding any current mental health symptoms, biological features of depression and potential suicide risk. Following discussion he

accepted that a current mental health assessment should have been conducted and recorded during this consultation including a suicide risk assessment.

b) The next relevant CBD concerning a consultation regarding mental health was on 26 January 2017 i.e. just over three weeks later. Amongst other matters it was agreed that his agenda in this consultation should have included completing a mental health and suicide risk assessment. He said that he presumed that the patient's presenting symptoms were in keeping with a "normal" reaction to a significant life trauma, but Dr Mehta and Dr Bevan discussed the need to evidence and underpin his instincts and assumptions with recognized and comprehensive history taking skills and coherent and complete medical record keeping. Dr Mehta's conclusion was that Dr Bevan failed to demonstrate competence in both of these areas. A further matter that resonated with the first mental health CBD was the absence of any record re safety netting.

c) On 3 August 2017 another CBD concerned mental health. The CBD included that Dr Bevan did not elicit specific mental health symptoms or undertake a suicide risk assessment as he felt "this patient has not got a mental health condition as she is only reacting normally to a recent trauma". Dr Bevan felt confident and reassured by his performance and did not feel that there were any difficulties or shortfalls in this consultation. He could not identify any learning needs or areas where improvement was needed.

d) Dr Mehta expressed her opinion that symptoms must be elicited and documented in this consultation to ensure good practice and care. He continued to disagree with her opinion and stated time constraints as a limiting factor to comply with eliciting a full mental health history. As he had failed to take a mental health history there is no foundation to base his diagnosis of adjustment reaction and anxiety and no justification to prescribe an anxiolytic or issue a Med3.

e) Dr Mehta gave feedback to Dr Bevan that the medical record keeping in this case was poor, not comprehensive and incomplete. Crucial and relevant information was missing such as specific mental health symptoms and suicidal risk. There is no safety netting advice documented, any arrangements for follow up/open door policy, counselling on the medication prescribed or agreement on the management plan. She considered that was very disappointing as they have discussed the need and importance of comprehensive and coherent documentation on many occasions when conducting past CBDs and discussing previous reflective learning logs.

The Paediatric/Antibiotic Cases

26. A case chosen for CBD on 16 February 2017 by Dr Mehta concerned diagnosis and treatment of a 4 month-old child presenting with cough:

    a) The initial consultation was via the telephone with the grandmother as historian. Although asking about fluid intake on the telephone Dr Bevan did not enquire about fluid intake at the face to face consultation the next day. After examination which revealed white spots to the pharynx Dr Bevan prescribed Erythromycin for 10 days. He considered pertussis (whooping cough) as a differential diagnosis although no clinical symptoms were consistent with that differential diagnosis.

    b) In the CBD Dr Bevan said that he recognised that a temperature reading should have been undertaken and recorded. Dr Mehta identified that no negative findings had been documented; the documentation was not comprehensive in that it did not provide any insight into the clinical presentation of the patient; important elements such as, alertness, fluid intake/wet nappies/hydration, rash, respiratory rate, capillary refill time, distress/discomfort, temperature/sats/respiratory rate were missing. The justification for antibiotic treatment was not in line with current guidelines. No safety netting advice was documented.

    c) Dr Bevan considered that this was a routine consultation with low complexity and he had performed satisfactorily in all three competencies. Dr Mehta expressed her concern with his performance and documentation in this consultation. There was no clear thought process or structure in his data gathering, examination and management plan, which is vital in any, but even more so in paediatric consultations. The NICE guidelines entail phenoxymeythylpenillin (in absence of an allergy to penicillin) as the first line treatment for streptococcii infections. She set out in detail the learning needs identified which included the use of the NICE traffic template for the assessment of a febrile child.

27. Another CBD concerning similar themes took place. This concerned a telephone consultation on 24 February 2017 just 10 days after Dr Mehta's feedback re her concerns as set out above. The telephone consultation concerned a 3 year-old child with cough and pyrexia. Dr Bevan demonstrated no awareness or use of guidelines of URTI management or assessment of febrile child. He agreed that the record entry did not provide any comprehensive information to allow safe practice and reaching an appropriate management plan. No negative findings were listed. Significant data was not elicited and recorded i.e. duration of symptoms, general alertness, fluid/food intake, urine output, respiratory distress, rash etc. No safety netting advice was recorded. Dr Bevan said that he felt confident and equipped with the right competencies to complete this clinical encounter. On reflection he felt that he should have offered a face to face consultation, but felt that *"sometimes short cuts are required and inevitable due to current pressures with workload in GP."* Amongst other matters Dr Mehta

recorded her view that Dr Bevan had shown no improvement and compliance in adapting consultation frameworks such as the traffic lights system for the assessment of febrile children although they had discussed and agreed the benefits in several previous clinical supervision sessions. She expressed to Dr Bevan her concern: *"you still lack any insight of your current performance, current deficiencies and learning needs. Your reflections do not demonstrate any self-awareness, honesty and identification of learning needs. You remain defensive to constructive feedback and criticism and even justifying your shortfalls due to workload pressures. I explained today that our profession does not allow any shortfalls, bad practice or shortcuts and if you feel that your workload/pressures are impacting on your performance you will need to review your work/life balance and make adjustments."*

28. In summary by the conclusion of supervision sessions in September 2017, Dr Mehta considered that Dr Bevan provided examples of good practice in encounters with limited clinical challenge/uncertainty and opportunity to reflect. She reached the conclusion that *"there has been very little and inconsistent progress in Dr Bevan's understanding of the reflective process. I concluded that this was as a result of his lack of self-awareness and honesty in his own performance which are essential attributes to engage with reflection and identify his learning needs and areas of improvement. As referenced in my last GMC report submitted in August 2017 I feel that closer and enhanced clinical supervision is needed to ensure safe and evidence-based practice and clear justification of his current clinical decision making."*

29. It is important to recognise that the illustrative cases were a small proportion of the 33 cases in which CBDs had been conducted, all of which are before us, and many of which involved similar themes. We have considered all the evidence to which reference was made by Mr Cawsey, as illustrative of compliance with some aspects of basic standards. As Dr Mehta acknowledged in her evidence that there was some evidence of reflection and/or improvement in some of the 33 CBDs undertaken. There was some evidence of good practice and she referred to the case in which Dr Bevan had diagnosed Lyne disease. Her point was that after nearly nine months clinical supervision there was no evidence of sustained and consistent improvement.

The Prednisolone Case

30. This case arose because Dr Mehta when working as a locum in the practice saw a 5 and a half month old child at an emergency appointment who had been treated by Dr Bevan on 26 September 2017 with prednisolone, a steroid. Her evidence was that the child presented to her with symptoms of thrush. Looking back through the medical record it was very difficult to unravel the decision-making process that had led to the use of steroids. The second concern was that prednisone prescribed at an incorrect dose for frequency and duration. The BNF for children advises one possible use of steroids was for croup, with a duration of two days, and always at 1 – 2 mg per

kilo, and the child was 8 kilos. Dr Bevan has not noted any weight recorded in the medical records. The prescription he gave was for 20mg (5mg qds:30 tablets). Dr Mehta said that the mother could not remember if the child had been weighed.

31. Dr Bevan's account is that he diagnosed asthma but this is inconsistent with the Read code that he used which was for croup. He maintains that he weighed the mother and the child together and the mother separately to reach the weight but did not record it. Before the reference panel he said that "*as far as I am concerned, it is no good that Dr Mehta was looking back at it, as she wasn't there, she didn't triage or see the child, and the outcome was good as far as the child was concerned."* He maintained before the reference panel that what he did was right, quoting from the BNF.

32. In our view it is clear that the prescription of steroids for 7 plus days was not in line with the BNF recommendations even if it was given for asthma. We noted that in the discussion in the RP meeting between LT (Deputy Medical Director) Dr Bevan agreed that it was difficult to diagnose asthma in a child under the age of two. LT has said that very few GPs would treat a child of 6 months aggressively with steroids, without specialist input. Dr Bevan's thoughts on this were to give more steroids (rather) than not enough, of which a Paediatrician had advised him. He said that the proof was the child was fine.

33. We consider it likely that the child was not weighed because we accept Dr Mehta's evidence that the mother could not remember the child being weighed and it seems likely that she would have remembered had it occurred. In any event the dose was greater than recommended, even assuming a weight of 8 kilos was correct, and even assuming that it was for asthma. We have already found that the Read code documented by Dr Bevan was for croup. Dr Bevan maintains that the child suffered no harm. We accept that the child's thrush could have been contributed to by the use of steroids which should not have been prescribed at a higher dose and a longer period than recommended by guidelines. She also suffered from loose stools which started 2 days after the prescription and which may have been attributable to the steroids.

34. Generally, Dr Bevan's broad response to the evidence of Dr Mehta was that her views reflected a different approach but that he is a safe practitioner. We recognise that it is true to say that the art of medicine is such that there is room for differing schools of thought in relation to diagnosis or treatment. However, any treatment prescribed has to be capable of being justified on rational grounds. The basis for any justification lies in appropriate clinical assessment which includes full history taking and the recording of both positive and negative signs. This is of important because it assists in the process of reaching a reasonable diagnosis and treatment at the time of consultation. It also assists GP colleagues who may have to consider and review the diagnosis and treatment at a later stage.

35. We have considered all of the evidence in the round. We found Dr Mehta to be a very impressive witness. She was measured in her evidence. She demonstrated her fairness. She conceded matters where appropriate. It is a mark of her measured approach that she was evidently unwilling to say that further training was not possible. She explained to us that this was because, as an educationalist, she has to believe in the power of education.

36. We have already noted some of the many instances where in his evidence Dr Bevan demonstrated his lack of insight. Having seen and heard him give evidence over a period of two days and having considered all the evidence, we formed the clear view that beneath the thin veil of his professed insight lay an entrenched attitude and resistance to true self-reflection or change. We agree with the submission that his evidence was inconsistent in that he tended to withdraw points that he had agreed. We consider that any concessions that he made were driven by the exigencies of the litigation rather than genuine reflection. In our view he lacks the attributes of true insight and self-reflection. He has little or no appreciation of the significant efforts that have been made to assist him in the delivery of consistently adequate care.

37. We find that his true attitude was reflected in the reference panel meeting several times: his position was that he has not made any mistakes. It was very apparent that he believes that none of the regulatory action imposed has been necessary. He said that he believed the whole scenario came about because of the original complaint to the GMC and he has not assaulted or killed anybody and had not done anything wrong. He also said this *"Regarding clinical governance, tell me where my errors are, were I have done things wrong, where are the complaints?"* Thereafter, he proceeded to explain to the reference panel that he disagreed with Dr Mehta's opinion. He expressed his opinion there are different ways of doing things in medicine but the outcome is the same.

38. It is, in our view, significant that although it is submitted that Dr Bevan should be retrained he himself gave only the vaguest outline of his own perception as to any training needs. In short, he said he would undergo training in areas such as paediatrics, record keeping and any other areas deemed necessary. This vagueness did not instil any real confidence that Dr Bevan accepts even now any identified deficiencies or that he takes any or any real responsibility for his own practice or learning.

39. Emphasis has been placed upon on Dr Bevan's difficulty in engaging in reflective practice as per the Gibbs cycle with Dr Mehta. On the evidence his inability to reflect and thus learn from the past mistakes in supervision was very apparent indeed on the evidence. We recognise that some practitioners may find the Gibbs cycle difficult, but in our view the onus is on the practitioner to take responsibility for his own learning and, if necessary, to find alternatives that may suit him better. We noted that Dr Mehta had attempted a different approach during her

clinical supervision sessions (as one method appeared not to be successful.) The evidence is that despite having the services of Dr O'Dwyer as an educational supervisor Dr Bevan did not seek his assistance regarding any difficulties with reflective learning.

40. Dr O'Dwyer signed a witness statement in which he said at para 18:

"It appears to me that of late Dr Bevan has been under an extraordinary amount of scrutiny by the Local Health Board who have been through his consultations in great detail and scrutinised any medication prescribed. In my opinion a lot of minor or trivial points have been raised and brought up with the GMC by the Local Health Board. I understand that the Local Health Board required Dr Bevan to work in partnership. I understand that Dr Bevan has tried to recruit a partner, which is not easy at the moment and he does not seem to have any assistance in this from the Local Health Board."

In cross examination he withdrew aspects of this criticism. It is apparent to us that his opinion was based on what Dr Bevan had told him.

41. Dr O'Dwyer's evidence was illuminating in relation to Dr Bevan's insight in that it became apparent that Dr Bevan had not raised the general themes repeatedly raised by Dr Mehta within educational supervision sessions. We noted also that Dr O'Dwyer expressed his frustration with what he saw as a lack of detail or guidance from the GMC as to the issues in the three areas he was asked to educationally supervise. It is notable in this regard that Dr Bevan himself did not share with Dr O'Dwyer the very comprehensive GMC Performance Assessment report from March 2016.

42. In short, Dr O'Dwyer subscribed to the view that there was nothing wrong with Dr Bevan's practice but we find that this was based on the information presented to him by Dr Bevan. It is notable that he believed that the issue regarding the prednisolone case was minor based on his view that a), the facts were as described by Dr Bevan, and b), Dr Bevan said that his use of prednisolone was supported by a text book. It was not apparent that Dr O'Dwyer had seen or considered this text. Whatever this may say about Dr O'Dwyer's objectivity or judgement, on any basis his evidence underlines the lack of Dr Bevan's insight and his lack of true engagement with the remediation process (including educational supervision) undertaken in order to assist him. We do not attach weight to Dr O'Dwyer's opinion that Dr Bevan is a reflective and insightful practitioner. In our view Dr O'Dwyer demonstrated in his evidence that he was not an objective witness. It became clear that his views were coloured by his opinion that local health boards in general are against GPs. We find that the evidence before us shows that the Board concerned with Dr Bevan had gone to great lengths to support him.

43. We accept the evidence of Ms Dover and Ms Miller. They were consistent and credible witnesses.

44. Dr Lloyd was not called to give evidence which affects the weight we attach to his evidence. In any event he ceased to practice with Dr Bevan in 2015. We do not consider that the evidence of Ms Delves or Mr Evans assists us a great deal. In our view Dr Mehta's meticulous supervision demonstrates very clearly the deficiencies in Dr Bevan's approach to practice, the lack of consistent progress and his lack of insight. In so far as there was any difference between the opinion of Dr O'Dwyer and Dr Lloyd we prefer that of Dr Mehta and Dr Roeves. Dr Roeves was an impressive witness whose evidence we accept without reservation. In our view his opinion regarding the prospects of retraining/remediation carry greater weight than that of Dr Mehta because of his strategic knowledge and experience.

45. We consider that Dr Bevan's practice poses a clear risk to the public interest in the efficiency of primary care services. The particular risks engaged are those of patient safety and well-being as well as the maintenance of public confidence in the ability of those who perform NHS primary services to provide a safe and appropriate service.

46. We were mindful of the long service that Dr Bevan has provided over his years as a GP in the NHS. Plainly any decision to remove Dr Bevan will have a significant effect on his standing and reputation and on his ability to continue to practice and earn his living in his chosen profession. We noted that his wish is to retire at a time of his own choosing.

47. We start from the premise that (absent removal on the grounds of unsuitability) proportionality requires that if appropriate conditions can be devised that will provide adequate or sufficient protection for patients and the public interest that is the course that should be adopted. We find that there is a long history of real and justifiable concerns regarding Dr Bevan's ability to consistently meet appropriate standards in relation to basic standards of care. In our view very significant measures have been employed over very many years in order to support Dr Bevan, and with significant resource implications, but to little or no avail. Consideration of the very large number of times that his case and circumstances, and the measures taken to support him, have been reviewed is relevant to the issue of the overall efficiency of the use of resources. Despite all of this input Dr Bevan has not made any significant or sustained progress. After a period of some10 years, issues regarding clinical competence, history taking and record keeping, all of which have the clear potential to impact on patient safety and well-being, remain a matter of real concern.

48. Mr Cawsey submitted that the lack of consistency in Dr Bevan's skills is a training issue. We do not agree that training, in and of itself, can ensure or improve consistency. The evidence clearly shows that despite clear feedback re learning points, as well as very specific identification of learning tools and the use of nationally accepted clinical guidelines, Dr Bevan has been unable to respond in a consistent manner. Having seen and heard Dr Bevan give evidence we consider it very unlikely that any training measures would effectively

address the deficiencies in his practice. In our view the core reason for the lack of any sustained success is that he has never truly accepted that there is any foundation to the concerns that have been consistently raised over the years by various bodies charged with the protection of patient safety and the public interest. In our view his true attitude is that which he had expressed to Dr O'Dwyer and which came across in his evidence to us: the matters raised were unimportant and the conditions imposed upon him unnecessary because he is a safe practitioner. He does not believe that he has anything to learn.

49. In our view his attitude to regulation provides the explanation for the fact that he did not comply with condition 8. He said at the reference panel meeting that he was unsure if September's educational supervisor's report had been shared, and was not aware if this had been done within a week of convening. He admitted in the Scott schedule that he did not send the report dated 29 September 2017. It may well be the reason is he was upset at the time given that he had been required to cease work by the GMC in early October but the fact is the condition was breached. This, in and of itself, would not, in our view, justify removal on efficiency grounds. It is, however, part and parcel of a picture which indicates Dr Bevan's approach and attitude to engagement with conditions is not consistent.

50. So far as Condition 11 is concerned Dr Bevan has had a very long time indeed since to seek to find a GP partner to supervise his practice at some level. He entered into partnership with Dr Sheeve who has not been able to become a practitioner in the MPL. That, of course, is not Dr Bevan's fault. However, he knew that the future of his own practice as a GP in the NHS depended upon him finding a partner to supervise his work and to take the lead in clinical governance. We find that he was given considerable support to that end.

51. It was always an option that Dr Bevan have sought a post either as a partner or a salaried GP in another practice. Negotiations regarding partnership in another local practice were facilitated by Ms Miller but to no avail. It was clear on Dr Bevan's evidence that he has not progressed the option of working as a salaried GP because he wants to continue to work part time as a partner within his own practice and then retire. This is a choice he has made in the context of his awareness of the detailed and evidence-based concerns of the GMC assessors and the respondent. It is not at all clear to us what, if any steps, he took to recruit a different partner after the Board's decision on 16 November 2017 because very little documentary evidence has been adduced to show his efforts in this regard. Although we recognise that there are some difficulties in GP recruitment we do not accept that this provides the real explanation for the fact that Dr Bevan has been unable to recruit a partner. His oral evidence in cross examination was that he had spoken, on the very day before the hearing started, to a candidate who was willing to become a partner. We noted with concern the fact that the advertisement placed was for a *salaried* GP. We listened carefully to the evidence he gave regarding his conversation with this potential candidate. This was to the effect that she was aware

that she would need to be a partner who would need to supervise him due to concerns regarding his practice. In our view the evidence Dr Bevan gave was very unsatisfactory indeed. It is odd, to say the least, that anyone seriously seeking to recruit a partner would advertise the post as that of a *salaried* GP. However, we do not need to dwell on this.

52. We find that if Dr Bevan were to remain in the MPL, it would be necessary to devise a raft of conditions which would include, at the *very* minimum, a condition in relation to supervised practice in order to protect the public interest in efficiency which includes patient safety. The next issue would be what level is supervision is necessary to protect the efficiency of services? Dr Bevan contends that the least restrictive level of supervision (as per the GMC definition) would be necessary. We disagree. His view reflects his lack of insight which, in our view, goes to the very heart of why conditions would not be effective. In our view it would be extremely hard, if not impossible, to effectively monitor the safety and efficiency of his practice by way of supervision unless by way of direct supervised practice which, in our view, is not practicable, workable or realistic in a practice of this size.

53. Fundamentally it is our view that *whatever* level of training and/or support and/or partner supervision were to be put in place, we consider it very unlikely that the deficiencies in Dr Bevan's practice would be remediated. We say this because Dr Bevan lacks any true insight into the deficiencies in his practice. His true and core attitude as shown by his oral evidence in this appeal is that the way in which he provides services is perfectly adequate. He believes that the absence of what he would judge to be "serious mistakes" or proven harm, or any complaint or claims for compensation, must mean that his performance is acceptable. We disagree. Substandard care can be given without demonstrable evidence of serious harm or complaint. Although Dr Bevan claims that he is willing and able to learn, both the past history and his oral evidence shows that he does not really accept that there is anything wrong with his practice. In our view he lacks any, or any real, insight or understanding of the risks of harm caused by deficient clinical practice in assessment as well as his inadequate recording of history and negative and positive findings. We find that his lack of insight inevitably seriously limits the capacity for any real or sustained improvement. We consider that his continued practice, even if subject to retraining and/or other conditions such as supervision, poses a clear risk to patient safety and the public interest in the efficiency of primary care services in the NHS.

Conclusion

54. We have considered the overall effects of the past history and all the evidence in relation to the current situation in the round. Having balanced the risks to the public interest in the efficiency of primary care services against the appellant's own interests, we consider that removal is the necessary and proportionate response on the grounds of inefficiency.

55. There is, of course, as inevitable overlap between efficiency and suitability grounds. We would add that our findings regarding Dr Bevan's lack of insight, his attitude to his practice and his lack of capacity for improvement would also support a conclusion that Dr Bevan is unsuitable to be included on the list. Whatever the position may have been in the past he has demonstrated that he lacks the essential attributes to be a safe and competent practitioner. The reality is that the deficiencies in his practice are irremediable because he lacks the capacity to improve because of his lack of insight. However, we have made the decision on the same grounds considered by the Board and remove Dr Bevan from the list on efficiency grounds.

THE DECISION

56. We confirm the respondent's decision and dismiss the appeal.

Rights of Review and/or Appeal

57. The appellant is hereby notified of the right to appeal this decision under section 11 of the Tribunals Courts and Enforcement Act 2007. He also has the right to seek a review of this decision under section 9 of that Act. Pursuant to paragraph 46 of the Tribunal Procedure (First-tier Tribunal) Health, Education and Social Care Chamber) Rules 2008 (SI 2008/2699) a person seeking permission to appeal must make a written application to the Tribunal no later than 28 days after the date that this decision was sent to the person making the application for review and/or permission to appeal.

Directions regarding Potential National Disqualification

58. We did not hear substantive submissions on this potential order pending our decision but invited submissions of directions. We now issue consequential directions:
    i. The respondent shall submit written representations on the issue of national disqualification within 7 days of receipt of this decision.
    ii. The appellant shall respond within 7 days thereafter.
    iii. Each party shall make representations in writing to the Tribunal within 21 days from receipt of this decision stating whether an oral hearing is sought or whether they wish the Tribunal to proceed to consider the issue of national disqualification on paper.

Judge S Goodrich
Primary Health Lists
First-tier Tribunal Health Education and Social Care Chamber

Date Issued:13 July 2018