IN THE FIRST-TIER TRIBUNAL
(HEALTH, EDUCATION AND SOCIAL CARE CHAMBER)
PRIMARY HEALTH LISTS

Case No: PHL/15390

Tribunal Members

Mrs Debra Shaw	**-**	**Chairman**
Dr Rajendra Rathi	**-**	**Professional Member**
Mrs Jane Everitt	**-**	**Member**

BETWEEN

DR ENTESAR HADAD
GMC No: 4285575

Appellant

and

HERTFORDSHIRE PRIMARY CARE TRUST

Respondent

Heard on 8th August 2011

DECISION WITH REASONS

The Application

1. This is an appeal by Dr Entesar Hadad against the removal of her name from the Medical Performers List of Hertfordshire PCT (the PCT) under the provisions of Regulations 10(4)(a) and (c) of the National Health Service (Performers Lists) Regulations 2004 (as amended) and associated regulations (the Regulations) on grounds of inefficiency and unsuitability.

History and Background

2. Dr Hadad qualified in Iraq and came to the UK in 1993. After working in UK hospitals for several years as a SHO and Registrar mainly in Obstetrics and Gynaecology she underwent GP Registrar training between August 2000 and February 2002 and was a full-time GP partner at the Maples Surgery, Herts, from September 2002 to February 2009.

3. In February 2009 Dr Hadad joined Stanhope Surgery (Stanhope) as a partner with the existing principal, Dr Hossain, working two days per week.

4. Following a number of complaints in relation to Dr Hadad's performance for the Out of Hours (OOH) GP service, in April 2009, a PCT Panel considered her suspension but instead decided to make a series of recommendations, including that she should

not undertake any OOH work, she should not work for more than 48 hours per week and she should undergo an occupational health assessment.

5. Dr Hadad was concerned this put her in a weak position at Stanhope Surgery as she was still in a probationary period. She also began to undertake two locum sessions per week at Acorn Medical Centre (Acorn) from June 2009.

6. Although the occupational health assessment did not identify any medical problems and no recommendations were made, the local Performance Advisory Group assessment highlighted concerns about Dr Hadad's insight, ability to learn from past performance and capacity to apply that learning for the benefit of future patients, which resulted in the PCT asking Dr Hadad to undergo a National Clinical Assessment Sevice (NCAS) assessment. As part of that process she underwent a further occupational health assessment in October 2009 and a clinical assessment in January 2010. That assessment determined Dr Hadad's performance was poor in core areas of her clinical practice, with some cases raising significant concern about the safety of patients. The areas identified as poor were:

    - assessment of patients' conditions
    - providing or arranging investigations
    - record keeping.

   In addition, concerns were raised by the occupational health assessor about Dr Hadad's cognitive function. NCAS recommended the current restrictions on her practice be maintained and appropriate supervision arrangements be put in place until the PCT was satisfied she was able to work safely.

7. In April 2010 the PCT undertook a review of Dr Hadad's patient records in light of concerns raised in the NCAS report that records had been inappropriately amended after consultation had taken place.

8. Following receipt of the NCAS Report Dr Hadad agreed to stop work whilst her health concerns were investigated, but she returned to work before a definitive diagnosis was made. In light of the PCT's concerns arising out of the NCAS report and Dr Hadad's response to it, the PCT decided to suspend her from its Performers List on 6th May 2010.

9. On 10th June 2010 the PCT received a report from Dr Kapur, an independent Consultant Neuropsychologist and Head of Neuropsychology at Addenbrooke's NHS Trust, Cambridge, from whom Dr Hadad had sought a second opinion. He rejected the suggestion of cognitive impairment.

10. The PCT also referred Dr Hadad to the GMC and its Interim Orders Panel (IOP) placed conditions on her practice on 10th June 2010 (having seen Dr Kapur's report) as follows:

1. She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the contact details of her employer and the PCT on whose Medical Performers List she is included, or the local Health Board/Health & Social Care Board if employed in Scotland, Wales or Northern Ireland.

2. She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.

3. She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination

4. She must inform the GMC if she applies for medical employment outside the UK.

5. She must obtain the approval of the GMC before accepting any post for which registration with the GMC is required.

6. She must confine her medical practice to posts within the National Health Service and not undertake any private practice.

7. a. She must confine her medical practice to general practice posts as a GP, where her work will be supervised by a named GP Trainer

   b. She must seek a report from her supervisor for consideration by this Panel, prior to any review hearing of this Panel.

8. She must not work as a locum or undertake any out-of-hours work or on-call duties.

9. She must inform the following parties that her registration is subject to the conditions, listed at (1) to (8), above:

   a. Any organisation or person employing or contracting with her to undertake medical work

   b. Any prospective employer or contracting body (at the time of application)

   c. The PCT in whose Medical Performers List she is included, or seeking inclusion (at the time of application), or the local Health Board/Health & Social Care Board if employed in Scotland, Wales or Northern Ireland.

. These conditions were amended on 13th August 2010, such that pursuant to condition 7, Dr Hadad's work was confined to general practice posts at Stanhope Surgery for a maximum of seven sessions per week (including locum sessions) and one session per week at the Cheshunt Community Hospital. On 28th September 2010 these conditions were further amended, such that Dr Hadad's general practice was not restricted to Stanhope Surgery, but she was still only permitted to work a maximum of seven sessions per week (including locum sessions). Locum work was only permitted with the approval of her clinical supervisor.

11. On 6th August 2010 the PCT revoked its suspension because a programme of clinical supervision had been agreed and the GMC had placed conditions on Dr Hadad's registration. In light of Dr Kapur's report it was also satisfied that suspension was no longer necessary to protect members of the public or was otherwise in the public interest.

12. In November 2010 Dr Hadad applied for a post at Neasden Medical Centre (Neasden), for which she was accepted. The PCT did not believe Dr Hadad had informed Neasden she had conditions on her registration, although she disputed this. However, she did fail to inform the GMC she had accepted this post and on 10th January 2011 the GMC wrote to inform her she had acted in breach of her conditions.

13. On 24th December 2010 Dr Hadad faxed Stanhope a copy of a sickness certificate signed by her GP declaring she was unfit to work for two weeks. This was faxed from Acorn and Dr Hadad continued to do locum sessions there during this two-week period.

14. In December 2010 and January 2011 Dr Birley, GP Principal at Acorn, conducted a routine review of the current registration status of all doctors working at Acorn, from which he discovered Dr Hadad's registration was subject to the GMC conditions. Dr Hadad had not told him or anyone in the practice about them and they had not previously been aware of them. Dr Birley therefore terminated Dr Hadad's contract with immediate effect on 6th January 2010.

15. In light of Dr Hadad's conduct the PCT wrote to her on 8th March 2011 to inform her it would be considering her removal from its Performers List pursuant to the following allegations:

    a. She had worked in contravention of a PCT suspension
    b. She had breached an IOP condition that she should not undertake any locum work
    c. She had breached an IOP condition that she should not work in excess of 7 sessions per week
    d. She had breached an IOP condition that she should notify employers and prospective employers of the conditions imposed upon her
    e. She had breached an IOP condition that she should notify the GMC before accepting any post
    f. She had breached an IOP condition that she should work under supervision of a named trainer
    g. She had worked whilst she was declared unfit for work by her GP
    h. She had amended patient records inappropriately

16. The PCT decided to remove Dr Hadad from its Performers List on grounds of inefficiency and unsuitability at a PCT panel hearing on 27th April 2011.

The Appeal

17. The Tribunals Service received an appeal application dated 18th May 2011 from Dr Hadad on the following grounds:

(i) that no or insufficient regard was paid to the decision of the GMC IOP, which was reached upon the same set of facts, and which determined to impose conditions on her registration rather than suspend her

(ii) that no or insufficient regard was had to the opinion of Dr Heatley, Dr Hadad's trainer in general practice, that she should be permitted to remain on the Performers List and complete her retraining.

The Law

18. The legal framework for this appeal is largely contained in the NHS (Performers Lists) Regulations 2004 which, inter alia, set out the criteria by which appeals are to be considered.

18.1 Regulation 10(4)(a) provides that a performer may be removed where his continued inclusion in the performers list would be prejudicial to the efficiency of the service which those included in the relevant performers list perform

18.2 Regulation 10(4)(c) provides that a performer may be removed where he is unsuitable to be included in that performers list

18.3 Regulations 11(1) and (2) set out the matters to which the PCT (and the Primary Health Lists First Tier Tribunal (PHL)) should have regard in an unsuitability case including, inter alia, the nature of any offence, investigation or incident; the length of time since any such offence, incident, conviction or investigation; whether there are other offences, incidents or investigations to be considered; any action taken or penalty imposed by any regulatory body as a result of any such offence, incident or investigation; the relevance of any offence, incident or investigation to her performing relevant primary services and any likely risk to any patients or to public finances; whether any offence was a sexual offence to which Part I of the Sexual Offences Act 1997 applies, or if it had been committed in England and Wales, would have applied; whether the performer has been refused admittance to, conditionally included in, removed, 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 PCT or equivalent body for such action

18.4 Regulations 11(5) and (6) set out the matters to which the PCT (and the PHL) should have regard in an efficiency case including, inter alia, the nature of any incident which was prejudicial to the efficiency of the services, which the performer performed; the length of time since the last incident occurred and since any investigation into it was concluded; any action taken by any regulatory body as a result of any such incident; the nature of the incident and whether there is a likely risk to patients; whether she 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 PCT.

18.5 Regulation 12 provides that the PCT (and the PHL) may remove a practitioner contingently, and impose conditions which can remove any prejudice to efficiency. If the performer fails to comply with the conditions the PCT (and the PHL) may vary the conditions, or impose new ones or remove the performer from the list.

18.6 Regulation 15 provides that the appeal to the PHL is by way of redetermination, and the PHL can make any decision which the PCT could have made.

18.7 We also took into account the relevant sections of the "Primary Medical Performers Lists Delivering Quality in Primary Care Department of Health 2004" (DOH Guidance) including sections 7 and 17.

18.9 The burden of proof of an issue is on the party who alleges it and the standard of proof is on the balance of probabilities.

Preliminary matters

19. Prior to the commencement of the hearing all three tribunal members confirmed they had not had any prior interest or involvement in the appeal that would preclude them from considering the evidence in an independent and impartial manner.

20. The persons present at the Tribunal were:

Dr E Hadad	Appellant
Ms E Davison	Counsel for the Appellant
Mr R Shipway	Solicitor for the Appellant (RadcliffesLeBrasseur)
Mr Parker	MDU Scotland on behalf of the Appellant
Dr P Heatley	Witness for the Appellant
Ms C Neal	Practitioner Performance Manager, PCT
Mr R Booth	Counsel for the Respondent
Ms A Hauck	Solicitor for the Respondent (Capsticks)
Ms S Ilyas	Professional Observer

The evidence

21. Over the course of the hearing we were presented with a large amount of written and oral evidence. For the purposes of our consideration of the evidence and this decision, we have summarized the most pertinent submissions and evidence from each of the witnesses.

Mr Andrew Parker (Director of Primary Care Development at the PCT)

22. As the facts at this hearing were not in dispute and Dr Hadad had admitted all the allegations against her, Mr Parker did not give evidence at the hearing. However, in his Witness Statement dated 13th July 2011 *(File 1, Tab 6, pages 40-44)* he confirmed the reasons for the PCT Panel's decision to remove Dr Hadad were that:

a. She was unable to give any objective evidence to counter the allegations
b. Her conduct meant the measures put in place by the PCT had been rendered pointless and ineffective and the PCT had therefore wasted resources in taking steps which Dr Hadad had disregarded
c. In light of the number of times Dr Hadad had breached her GMC conditions and contravened the PCT suspension, the PCT Panel had no faith that she would abide by any further measures to monitor or supervise her work
d. Dr Hadad had sought to justify and minimise her actions. Her reasoning in so doing demonstrated a profound lack of insight and her arguments had little or no merit in the context of a doctor enjoying the privileges offered to a GP, which include the trust to carry on a highly autonomous professional life
e. Dr Hadad's conduct demonstrated a lack of honesty and integrity in her professional dealings which was incompatible with her professional obligations set out in the GMC's publication "Good Medical Practice".

23. The PCT Panel had considered the IOP's decision but it did not materially influence them as the GMC was a separate body with a distinct role and an IOP makes no findings of fact in relation to the exercise of its powers. The PCT's role was in part to make findings of fact and, where appropriate, to impose a sanction. The PCT was responsible for managing the delivery of NHS services within its locality and had to make its own decisions as to the suitability of GPs who perform those services. The PCT Panel came to its own decision that Dr Hadad was unsuitable and inefficient within its locality.

24. The PCT Panel had considered Dr Heatley's letter to Mr Shipway dated 23rd February 2011 *(file 1, Tab 5, pages 37-39)* in support of Dr Hadad's case, but whilst it considered his opinion that Dr Hadad now understood that what she had done was wrong and was unlikely to do it again, the Panel came to its own conclusion she had repeatedly demonstrated dishonest conduct in her professional activities over a number of months and disagreed with Dr Heatley about the likelihood that she would repeat her behaviour. Further, Dr Hadad's letter was for the purposes of the GMC hearing and did not refer to Dr Hadad's continued inclusion on the Performers List; nor did it refer to her inappropriate amendments to patient records in preparation for the NCAS assessment. Dr Heatley had also provided the PCT with a witness statement dated 28th February 2011 *(file 1, Tab 5, page 35)* which confirmed Dr Hadad had worked as a locum without informing him and therefore without his approval and supervision, which contravened the GMC conditions. He had also confirmed that Dr Hadad had not informed him that she had worked whilst suspended by the PCT.

25. Mr Parker also submitted he considered contingent removal on appeal would be inappropriate. Dr Hadad had indicated financial pressures, a love for her job and a wish to maintain her clinical knowledge had lead her to work in contravention of both the GMC conditions and the PCT suspension, but she should have sought to address those concerns in other ways. Mr Parker considered there was a high risk she would act in the same way again if those circumstances continued or arose again. The PCT

Panel had had no faith that Dr Hadad would abide by any further measures to monitor or supervise her work.

26. Dr Hadad's lack of honesty and integrity in her professional dealings was central to the range of allegations against her. Mr Parker did not consider this could be remedied by the imposition of conditions, which were not an option, in any event, when a performer was unsuitable.

Mr R Booth (Counsel for the PCT)

27. At the hearing Mr Booth referred the Tribunal to section 7 of the DOH Guidance which states that efficiency *"broadly speaking"* relates to *issues of competence and quality of performance"* whilst suitability "*could be relied on where there is a lack of tangible evidence of a doctor's ability to undertake the performer role (for example, ...essential qualities."* The PCT's case was that honesty and probity were essential qualities in a practitioner.

28. He also referred to Dr Birley's evidence in his witness statement *(File 2 Tab 9 pages 92-95 para 9 and paragraph 14 above)*. Dr Birley said Dr Hadad was one of the quickest (if not the quickest) doctors to respond to requests to do extra sessions to cover for absent doctors.

29. Mr Booth pointed out that despite her sickness certificate signed by her GP declaring she was unfit to work for two weeks dated 24th December 2010, Dr Hadad continued to do locum sessions at Acorn Medical Centre during this two-week period.

30. He also emphasised Dr Heatley's evidence that Dr Hadad had worked as a locum without informing him, without his approval and supervision, which contravened GMC conditions and that Dr Hadad had not informed him that she had worked whilst suspended by the PCT.

31. Mr Booth went through the PCT's allegations against Dr Hadad *(see paragraph 15 above and File 2, Tab 1, pages 1-10))* and also emphasised the conclusions of the NCAS assessors (File 2 Tab 3 page 69) that Dr Hadad's performance was poor in three areas and her practice was inconsistent in seven areas and there were further areas of concern in relation to her management of medicines and her record keeping, as she had retrospectively added information to five records NCAS had reviewed, sometimes several months after consultations, without including any reason for doing so. He also pointed out the NCAS occupational health assessment had indicated cognitive impairment, although he made it clear that the PCT did not make Dr Hadad's health any part of the PCT's case.

32. Mr Booth also pointed out that when the PCT had decided to review Dr Hadad's patient records following the NCAS report, it had found 31 out of 71 records reviewed had been amended more than three days post consultation. There were 41 amendments, 34 of which were made on 13th, 15th, 16th and 17th December 2009, just before the NCAS assessment and all bar one of the amendments had been made after the date that patients had consented to NCAS looking at their records *(File 2, Tab 4, pages 79-82)*.

33. Mr Booth emphasised that Dr Hadad had admitted all the allegations against her, and it was the PCT's submission that these issues went to unsuitability rather than inefficiency although there were significant collateral issues of inefficiency. Given the duration and persistence of dishonesty and lack of insight and integrity, the PCT could not be confident that Dr Hadad would abide by any further measures to monitor or supervise her work. Significant resources had already been wasted.

34. "Good Medical Practice" provides that:
    - A doctor must treat his colleagues fairly and with respect
    - Probity means being honest and trustworthy, and acting with integrity; this is at the heart of medical professionalism
    - A doctor must make sure that his conduct at all time justifies his patient's trust in them and the public's trust in the profession
    - If a doctor is suspended by an organisation from a medical post, or has restrictions placed on his practice he/must without delay, inform any other organisations for which he undertakes medical work and any patients he sees independently.

    Trust was at the heart of any relationship of any medical professional and her regulator, colleagues and patients and that trust had been broken so many times the PCT could have no confidence that conditions would be complied with.

35. <u>In response to questions,</u> Mr Booth confirmed that the issue of Dr Hadad's competency was only at issue in this appeal as background as there were no patient records in the evidence, and complaints were not part of the PCT's case in relation to her suitability.

Ms E Davison (Counsel for Dr Hadad)

36. Dr Hadad's appeal was on the basis it was an efficiency case and the context in which her conduct occurred was so unusual and traumatic that it lifted it out of the unsuitability category into the efficiency category. The misdiagnosis of Dr Hadad's cognitive state meant she was unable to fulfil her partnership commitments at Stanhope Surgery and Dr Hossain terminated the partnership, having amended their partnership agreement to allow him to do this after three months. Dr Hadad was then in very difficult financial circumstances and also prevented from pursuing her career. This was not advanced as an excuse for the poor choices she made but to show they were not so poor that they made her unsuitable. Dr Hadad was very shocked when told she might have cognitive impairment. Although the second opinion she sought from Dr Kapur showed this not to be the case, the time it took to resolve meant her partnership was terminated and she took the decision to work elsewhere in breach of the GMC conditions and the PCT suspension.

37. Dr Hadad also relied on the medical reports of Dr Burnett and Professor Ikkos *(File 1, Tab 7, pages 46-66)*. The concerns had arisen at a time when Dr Hadad was considerably overstretched, fulfilling her partnership sessions, her OOH work and her session for her special interest in gynaecology. She now had a clean bill of health but because of the misdiagnosis of cognitive impairment she was facing the consequences of her very poor decisions. It was conceded there were grounds to consider her under inefficiency by virtue of her breaches of conditions but they were indicative of an

individual struggling in highly unusual circumstances rather than of her true character, professionalism or career as a GP.

Dr Hadad

38. Dr Hadad accepted she had amended patient records. She had added information if she had, for example, sent patients for tests and filled in the hospital form but not put it in the records or had not entered a code for diagnosis. She made amendments if she remembered what she had done.

39. If conditions were placed on her on a contingent removal Dr Hadad would abide by them. She had acted unprofessionally and she was ashamed and embarrassed; she would never do it again.

40. <u>In response to questions</u>, Dr Hadad admitted she had been repeatedly dishonest between May 2010 and January 2011. She accepted as a general principle there was no place in general practice for a dishonest GP

41. Dr Hadad had seen Dr Kapur in June 2010. He had concluded there was no reason why she should not return to work on health grounds, but even though her misdiagnosis was no longer an issue she still could not work as her PCT suspension had not been lifted.

42. Following the GMC hearing on 10th June 2010 when the IOP imposed conditions which, inter alia, prevented Dr Hadad from doing locum work, she went straight to a locum session at Acorn. It was not the case that she had no respect for the regulator. She was very stupid and regretted what she had done. At the time her judgment was wrong but she wasn't thinking properly. She had been misdiagnosed, she didn't have a problem working at Acorn and it was something to keep her alive. She didn't tell anyone what she was doing, not even close friends. It was very hard to keep going but she was absolutely wrong.

43. When Dr Hadad was suspended by the PCT in May 2010 she did not work at Stanhope but she carried on working at Acorn because she knew she would lose her position at Stanhope but she had not had any problems working at Acorn for the last year. It was an absolute nightmare; she would never do such a thing again.

44. Dr Hadad had very high financial commitments at that time. She tried to speak to the PCT every week for an early review of her suspension because Dr Hossain had told her he would end their partnership agreement after three months if the PCT didn't reinstate her.

45. At the time she felt she needed to get out to work; the days she worked were the only days she could get out of bed. It was not just the money; it was for her own sanity. She had never experienced anything like this. She had never stopped working in her life.

46 Dr Hadad had not told the IOP about her locum sessions at Acorn when she had a further hearing on 13th August 2010, at which her conditions were varied to allow her to do seven sessions per week at Stanhope (including locum sessions) and one session

per week at the Cheshunt Community Hospital. She undertook another locum session at Acorn the following day.

47. On 28th September 2010 these conditions were further amended on the papers, such that Dr Hadad's general practice was not restricted to Stanhope, but she was still only permitted to work a maximum of seven sessions per week (including locum sessions). Locum work was only permitted with the approval of her clinical supervisor. Again, she failed to inform the GMC about her work at Acorn.

48. Nor did she tell Dr Heatley about her work at Acorn at any of their regular sessions.

49. Dr Hadad accepted that trust was fundamental in her role as a practitioner and she had repeatedly breached that trust.

50. She had not given the Practice Manager any documentation when she went to Neasden Medical Centre because she had gone to see Dr Rasooly herself and taken along her old CV, which only went up to February 2009, but she had told him the Stanhope story and about her GMC conditions. When asked if she had told Dr Rasooly about her locum sessions at Acorn Dr Hadad initially said she couldn't remember but then admitted it was unlikely because she was desperate to keep the facts hidden.

51. Dr Hadad had not done any OOH work since March 2009 and would never do it again. In February 2009 she had started working for two days per week at Stanhope, increasing to four days in April 2009. When she started at Acorn in June 2009 she did two sessions per week on Thursday afternoon and Saturday morning.

52. Dr Hadad knew her record keeping was very, very bad when she was working OOH. With the help of Dr Heatley she learnt touch typing and her record keeping became much better.

53. She was not sure she had ever gone back to amend records prior to December 2009 but she only added tests and referrals she remembered or diagnoses that she had not inserted at the time. which she went back and coded for QOF. She denied it was to make her look better to NCAS; she didn't insert things she hadn't done, she wanted to make the records more comprehensive, but she accepted it was not usual practice to make 14 amendments in a single day. At the time she did not know that she needed to make it clear that amendments to records were made retrospectively.

54. When she went to see her GP, Dr Munro, for a sickness certificate on 24th December 2010, Dr Hadad did not tell her she was going straight back to work that afternoon. She had done it because the situation at Stanhope was too stressful; she knew she would be finishing there and she couldn't face it anymore and she felt nauseous and ill going there. She had tried to hold on at Stanhope because of her supervision sessions there or she would have left earlier. She had never been off sick her entire life and she didn't feel that way working anywhere else. She accepted she had deceived Dr Hossain but rather than admit to also deceiving Dr Munro and Dr Birley, she submitted by way of explanation that she felt she couldn't tell Dr Munro she was working at Acorn and Dr Birley didn't know about the sickness certificate.

55. Dr Hadad denied she regarded her own view of her capabilities as trumping the GMC's view. Her work at Acorn was her only source of income, but it was not just that, it was the only thing keeping her alive. She was not happy and felt she was going to be found out, but at the time she needed and had to work and keep going in life. She was wrong and would never do it again

56. Dr Hadad did not tell Dr Heatley about her locum sessions at Acorn until he found out. She had been stupid and naive. She had felt that it was alright as long as she was providing a service to patients and doing her job properly and Dr Birley was happy with her work, but she was wrong. She had denied working at Acorn on the first occasion Dr Heatley challenged her and she had failed to tell him about two patient complaints because one proceeded April 2009 and the other was not clinical. When she had told him about doing locum sessions at Acorn when signed off sick she explained she didn't have enough to pay her tax in January 2011.

57. Dr Hadad had felt her voice was not being heard at all at the PCT. She felt the |PCT was supporting Dr Hossain but ignoring her. She felt the PCT didn't want to revoke her suspension; it took two months to do so after Dr Kapur's report although she had written to the PCT within 28 days asking for the suspension to be lifted. She wasn't angry but felt it was unfair; she kept on explaining she didn't have cognitive impairment but was not given the opportunity to have a meeting about the diagnosis. When she was removed she was upset and unhappy but before removal she felt unfairly treated.

58. Dr Hadad had always been very good at what she did; she loved her job and found it difficult to accept her position. She knew she had had OOH complaints which she should have addressed but felt her misdiagnosis lead to over serious consequences and it shattered her life.

59. When challenged that her suspension was not just based on her misdiagnosis but also on areas of poor performance, Dr Hadad disagreed and said that it was.

60. Dr Hadad had felt ashamed about both her suspension and the diagnosis of cognitive impairment. She could not differentiate. She had been told she could not work because of cognitive impairment but she knew she did not have it. She wasn't ill. The NCAS assessment had indicated some clinical issues but they weren't a big deal; Dr Heatley couldn't find the same issues flagged by NCAS.

61. Dr Hadad had told her friends about the imposition of GMC conditions but she felt too embarrassed and ashamed to apply for jobs with them. At one point Dr Birley had said he would never employ someone like that. She knew it was wrong not to tell him or anyone at Acorn.

62. In continuing to work outside the terms of her supervision Dr Hadad did not consider she was potentially putting patients clinically at risk but acknowledged she was risking their trust in the profession and putting patients at risk in her conduct as a professional. In fact, she was studying more to ensure she didn't miss anything and putting everything in the records. She was always updating her clinical performance

63. Dr Birley knew she was not putting patients at risk clinically; he would always give her first option to do extra sessions.

64. Dr Hadad accepted the criticisms levelled at her in the NCAS report to a certain extent. She accepted her record keeping was her major downfall and possibly her failure always to keep updated. She didn't think she was doing anything wrong clinically; Dr Birley had not ended her contract for clinical reasons.

65. Dr Hadad had initially continued to deny working at Acorn even when she was found out; it was a mistake but she knew it was serious and she felt she couldn't tell anyone.

66. When she had an IOP review hearing on 7th March 2011 the GMC was made aware of her work at Acorn and the mistakes she had made. She had promised not to do it again and she had been given a final chance.

67. Dr Hadad had not applied for her job at Neasden Medical Centre. She had been recommended by a friend. She had thought she would ask Dr Heatley for a supportive letter and if she got the job she would inform the GMC and the PCT but Dr Heatley's staff told them beforehand. She had learnt from this and when she was offered the posts at Chamberlayne Road Surgery and St George's Medical Centre she informed everyone before she took them.

68. This part of the hearing was heard in private

69. She was also asked if it was her opinion that a person assessed as possibly having cognitive impairment was the right person to assess whether she did in fact have it. She replied that she had asked her family and friends, some of whom were GPs. She had not told them exactly but they were all surprised to hear when she asked if they had any concerns about her or if they felt she might have dementia. Her opinion that she did not have cognitive impairment was not solely based on her own opinion.

70. Given her deception in terms of not telling her supervisor and working at Acorn, Dr Hadad was asked if she considered she was the best person to make the judgment that she was not putting patients at risk clinically. She replied that she was not but she had been supervised indirectly by Dr Birley at Acorn.

71. Dr Hadad wanted to work in Hertfordshire in the future because she lived there. She was not applying for any jobs at the moment because she was too embarrassed; she would only take posts she was recommended to, but it would not prevent her from disclosing proceedings if she applied to another PCT because she knew she had to.

72. Dr Hadad had told Dr Rasooly everything about Stanhope and her GMC conditions but she had not told him about working at Acorn because she hadn't told anyone.

73. When she went to see Dr Rasooly Dr Hadad was doing three sessions at Acorn and five at Stanhope. Dr Rasooly offered her one session per week in January 2011 and said he would give her more if it went well. In February 2011 she took her annual leave at Stanhope because she was leaving and she had already had to leave Acorn. She was currently doing six sessions per week; two sessions at Neasden, three sessions at Chamberlayne Road Surgery and one session at St George's Medical Centre

74. At this point Mr Booth asked to make it clear that there was not an absolute prohibition against retrospectively amending notes, but it had to be made clear on the face of an entry that it was being made retrospectively.

75. On re-examination, Dr Hadad confirmed that when she met with Dr Rasooly he had both checked the GMC website and phoned Dr Heatley.

76. She also confirmed that Dr Kapur's second opinion about her cognitive impairment was completely independent and he was entirely unconnected to her.

77. This part of the hearing was heard in private

78. This part of the hearing was heard in private

79. She had fully complied with all the GMC IOP conditions imposed on her on 7th March 2011.

80. Dr Hadad was not seeking to distance herself from responsibility for the decisions she took. She had learned a lesson and to cope better and she would not do the same again. She should have behaved in a professional way with better judgment. In future she would abide by conditions imposed on her by the GMC and PCT.

81. This part of the hearing was heard in private

82. Dr Hadad had commenced working at St George's Medical Centre on 19th July 2011 for one session per week. She had informed everyone beforehand and sent an email to the GMC, the PCT and Dr Heatley.
(At this point Ms Neal of the PCT denied receiving any such email but Dr Hadad was able to produce a copy of an email she had sent to Dr Heatley and copied to Ms Neal on 30th June 2011 confirming this.)

Dr Paul Heatley

83. In his Witness Statement dated 2nd August 2011 *(File 1, Tab5, pages 32-33)* Dr Heatley referred to the accuracy of the contents of his letter to Mr Shipway dated 23rd February 2011 and his witness statement dated 28th February 2011 *(see paragraph 24 above)*. He acknowledged that Dr Hadad had amended patient records in advance of the NCAS review but it was his understanding that she realised the deficiencies in her note keeping and sought to make the records more complete in advance of the review. Since then Dr Hadad had sought to address the deficiencies in her record keeping; she had taught herself to touch-type and he considered the records she now made were certainly adequate. He also confirmed with regard to her work at Neasden Medical Centre that Dr Hadad had spoken to him about a possible locum position before she met Dr Rasooly. He submitted that from his experience of Dr Hadad and his observations of her he did not consider she represented a danger to patients. She was a competent doctor and enthusiastic about the practice of medicine and the care of her patients. She had been undertaking supervised sessions at his practice and he and his partners were happy with her work, she had received positive feedback and they would be happy to employ her as a locum.

84. At the hearing Dr Heatley reiterated they would be happy to employ her as a locum once her supervision had ended. There had been no negative feedback and they were happy with her standard of record keeping.

85. On questioning, Dr Heatley confirmed that Dr Hadad had not mentioned working at Acorn at any of their supervision sessions before Christmas 2010. It was five months before he became aware of this.

86. At the supervision sessions they had focussed on the NCAS issues of performance in the early stages of the process but he was also guided by what he saw when he sat in on her surgeries. They had also discussed clinical and management issues. The normal format was for him to sit in on her surgeries at her practice and at his practice he was available for her to talk to him. They had also spent significant time discussing probity issues.

87. It was the first time he had been asked to supervise a doctor under GMC conditions but he had experience with failing Registrars with probity issues. Dr Hadad's failure to disclose her work at Acorn was certainly disappointing.

88. When in his letter dated 23rd February 2011 he had stated that Dr Hadad now understood that what she had done was wrong and was unlikely to do it again, he had taken the same approach as he would with a Registrar, hoping that over a period of time Dr Hadad would come to an understanding that what she had done was wrong and she would be fit to practise in the future.

89. As the supervision process evolved Dr Heatley did not think the clinical issues raised by NCAs or the OOH complaints were a problem, but he did feel Dr Hadad had made some very unwise decisions in not disclosing her locum work, but she had gradually come to understand the implications.

90. Dr Hadad had readily agreed with the NCAS criticisms of her record keeping. It was one of the issues they had looked at very early on and she had taught herself to touch type and now kept very accurate records. His impression was that she was aware some of her records were very scanty and she wrongly went back and amended them, but based on what she said she was embellishing and polishing rather than seeking to mislead.

91. Dr Heatley thought he had had a telephone conversation with Dr Rasooly before Dr Hadad was about to start working for him.

92. Dr Heatley was not concerned about Dr Hadad's clinical performance as a GP but there was cause for concern in relation to her response to the imposition of GMC conditions.

93. With regard to the mismatch in terms of clinical performance between what NCAS found and he had found, Dr Heatley thought several NCAS observers had come for three days and Dr Hadad may not have understood what it was about, she may have been very stressed and she may not have performed as well as she could; she had to

be natural, The NCAS report could have highlighted deficiencies which Dr Hadad had thought about, understood and put right.

94. Taking the wider picture and not just her clinical performance, Dr Heatley would be happy to employ Dr Hadad as a locum. The GMC had been aware of Dr Hadad's flagrant breaches of conditions and allowed her to continue with supervised practice, which was why he had made representations to the PCT before it considered her removal asking for her to be given one last chance. He thought she now understood the boundaries and who to ask if necessary.

95. Dr Heatley was not sure if Dr Hadad understood what went on around the time of her cognitive assessment; she was sent for a psychometric assessment and initially found to be a couple of marks below the pass level, asked to take time off, then suspended. He was not suggesting Dr Hadad had cognitive impairment but that this set off a chain of events which she possibly didn't understand and the whole situation spiralled from some complaints about OOH work.

96. The fact Dr Hadad continued to work suggested to Dr Heatley she didn't understand her position. He felt she now had a much better understanding and he didn't think she would do it again.

Closing Submissions

97. Counsel for the PCT submitted that, in essence, the PCT's position remained the same as before; Dr Hadad had admitted each of the allegations before the PCT Panel and this Tribunal had to consider issues as to the state of her mind, insight, honesty and integrity in relation to the central question of Dr Hadad's suitability.

98. One of Dr Hadad's grounds of appeal was that the PCT Panel had failed to take sufficient account of the IOP decision on 7th March 2011. The significance of this was that the IOP knew about Dr Hadad's breaches, but instead of interim suspension they varied certain conditions. However, the IOP do not make findings of fact, they did not hear and had never heard evidence from Dr Hadad, and the role of the IOP is to regulate within the wider sphere of the medical profession whereas the role of the PCT is to regulate NHS Primary Care by the management of its Performers List, that is, their functions are different.

99. The other ground of Dr Hadad's appeal was that that no or insufficient regard was had to Dr Heatley's opinion that she should be permitted to remain on the Performers List and complete her retraining. The PCT's position *(File 1, Tab 2 pages 13-16, paras 13-15)* was that although Dr Heatley did not have significant concerns about Dr Hadad's clinical practice, he had registered his concern about the breach of her GMC conditions and her lack of full engagement with the supervision process, he had ascribed her conduct to the fact she did not have any significant interests outside her work and her need for money, Dr Hadad had offered no reason to him for failing to inform him about the locum sessions she did whilst she was signed off sick and Dr Heatley did not provide any reasons why he believed she would not repeat this conduct. The PCT Panel had given due and appropriate weight to Dr Heatley's

evidence, but felt Dr Hadad's persistent breaches of both the PCT suspension and the GMC conditions, together with her inappropriate amendment of records and her decision to work in contravention of her sickness certificate, demonstrated a pattern of dishonest conduct and repeated disregard for the PCT, her regulatory body, her colleagues and employers and made her unsuitable to be on its performers list. The PCT also considered that resources had already been wasted on taking steps which had been disregarded by Dr Hadad, which was an inefficient use of resources and it had no faith she would abide by any further measures taken to monitor or supervise her work.

100. This was not a one-off case of dishonesty but a lengthy period of deliberate concealment of her Acorn work. Dr Hadad had also amended patient records in December 2009 when she knew NCAS was coming and had shockingly obtained a sickness certificate between working two locum sessions that day at Acorn.

101. The Tribunal now had some medical evidence from Dr Burnett and Professor Ikkos for the period after March 2010, which post dated Dr Hadad's amendments to the medical records in December 2009.

102. This part of the hearing was heard in private

103. In relation to Dr Heatley's opinion and evidence, it was the first time he had been appointed as a supervisor for GMC purposes. It also appeared he did not go into significant detail with Dr Hadad in relation to her amendments to records in December 2009. He had very fairly said that her clinical skills met the required standard but her regard for her regulator was a cause for concern.

104. When considering suitability the Tribunal would wish to focus on the evidence it had heard from Dr Hadad. Elements of her evidence showed that, at times, she had difficulty with the concept of candour. When asked, she initially said she could not remember if she had told Dr Rasooly about her locum sessions at Acorrn, but when pressed she conceded she almost certainly did not tell him. Her evidence was also unconvincing in relation to knowing that she had to make it clear that amendments to records were being made retrospectively.

105. Dr Hadad was also inconsistent in her evidence as to whether she knew at the time what she was doing was wrong; she told Professor Ikkos she did not think she was doing anything wrong but she told the Tribunal that she did know what she was doing was wrong.

106. Dr Hadad showed a disturbing lack of insight into the risk to patient safety posed by her working at Acorn without supervision despite the NCAS conclusions and the IOP conditions imposed on her in June 2010.

107. Finally, the Tribunal might feel Dr Hadad remained reluctant to tell others of the restrictions on her practice which might raise concerns with regard to her safety as a practitioner and her appreciation of her own limitations.

108. Counsel invited the Tribunal to find that Dr Hadad was unsuitable to be included in the PCT's Performers List by reason of her repeated dishonest conduct, lack of

integrity, lack of insight and disregard for patient safety. Further, or in the alternative, her continued inclusion in the Performers List would be prejudicial to the efficiency of services and contingent removal would not satisfy the breadth and depth of the fundamental deficiencies displayed by Dr Hadad on the admitted facts.

109. Counsel for Dr Hadad conceded that the IOP makes no findings of fact. However, the PCT was required to exercise its powers in a proportionate way, compatible with the principles of natural justice. The sanction had to be proportionate and a decision that Dr Hadad was unsuitable leading to mandatory removal would be disproportionate when the full facts and context of this case were known.

110. The IOP determination on 7th March 2011 had been a full review with knowledge of all the circumstances. Even in light of that the IOP chose to impose conditions on Dr Hadad. Counsel submitted this was a proportionate response and the Tribunal should impose contingent removal with conditions.

112. Dr Heatley gave evidence seeking one last chance for Dr Hadad despite knowing all that had happened.

113. This case warranted special treatment because of the highly unusual circumstances in which Dr Hadad found herself, initially because of limited concerns about her OOH work. There had been no concerns about her day to day clinical performance and the NCAS assessment made it clear it was limited to OOH practice at a time when Dr Hadad was particularly stretched. As a result of the initial NCAS assessment the occupational health assessment lead to a diagnosis of cognitive impairment because Dr Hadad was two points below the required standard in one very discrete area. Whilst Dr Hadad had not chosen to excuse herself from the decisions she made, Counsel asked the Tribunal to put itself in her position. Unsurprisingly, this diagnosis was a great shock to Dr Hadad and she found it hard to reconcile herself to it. She ultimately sought a second opinion and Dr Kapur found no cognitive impairment in June 2010, but it was not until August 2010 that the PCT reconvened her case and lifted her suspension, and that lost time allowed Dr Hossain to terminate their partnership agreement. This plunged Dr Hadad into difficult financial circumstances and depression which was diagnosed by Dr Burnett and Professor Ikkos; Dr Hadad could only get out of bed on the days she was going to work. These very difficult circumstances were very strong mitigation for the decisions Dr Hadad took.

114. The Tribunal had had the advantage of hearing Dr Hadad's evidence. She was full and frank in accepting she had made very poor choices; she showed a good level of insight that she should not have made those choices and she was very clear that she would abide by any conditions placed on her in the future. The Tribunal could test that assertion by knowing Dr Hadad had complied with the GMC conditions placed on her with regard to her latest appointment; she had notified the PCT, the GMC and her supervisor. If the Tribunal gave Dr Hadad the final chance she was seeking she would abide by the conditions.

115. The IOP had imposed conditions on Dr Hadad *(File 2, Tab 14, pages 111/112)* and Counsel invited the Panel to impose conditions reflecting those, particularly standard conditions 1 to 4 and 10a and b. as follows:

1. She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the contact details of her employer and the PCT on whose Medical Performers List she is included, or the local Health Board/Health & Social Care Board if employed in Scotland, Wales or Northern Ireland.

2. She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.

3. She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination

4. She must inform the GMC if she applies for medical employment outside the UK.

10. a. She must not work as a locum, except under the approval of her clinical supervisor(s)
b. She must not undertake any out of hours work or on-call duties.

116. Counsel submitted Dr Hadad's breach of conditions when applying to work for Dr Rasooly was technical; she had informed both Dr Rasooly and Dr Heatley of her conditions and she may have been under the misapprehension that Dr Heatley would inform the GMC. The IOP accepted this breach could have been a misunderstanding at the review hearing on 7th March 2011.

117. The IOP had had before it all the information the Tribunal had about the number and extent of breaches, and the supportive reports from Dr Heatley and Dr Rasooly, and whilst it considered there had been intentional breaches of conditions and did not make findings of fact, it did find Dr Hadad had good insight in March 2011, so she should not be characterised as having lack of insight.

118. Dr Rasooly's current view was that having known Dr Hadad since January 2011, he considered she was a doctor of great integrity, was extremely dedicated to her work and her patients, had a great deal of initiative and was always ready to lend a hand. He said she was always punctual and willing to stay late to complete her work and she created a good rapport with patients and staff and he would confidently offer her additional locum work if it arose *(File 2, Tab 15, page 156).*

119. This and Dr Hadad's other testimonials from patients, certificates of accreditation, multi-source feedback and questionnaires from practice staff at Stanhope Surgery *(File 2, Tab 150)* showed Dr Hadad's true character. Though what had happened was gravely concerning, the Tribunal should consider it was a very unfortunate episode in Dr Hadad's career, mainly because of the misdiagnosis of cognitive impairment, which was beyond her control.

120. The DOH Guidance made it clear that discretionary powers to remove from the list bite when it is necessary (paragraph 17.3). This doctor was not a risk to patients and the DOH Guidance indicates where issues appear to be capable of resolution by remedial and/or supportive action before patients are put at risk, a formal removal action may not be appropriate.

121. It was accepted that Dr Hadad's past conduct breached the efficiency requirements.

122. It was not accepted that the misdiagnosis of cognitive impairment meant that Dr Hadad's health rendered her inefficient or a risk to patients.

123. Dr Hadad gave evidence of the extent to which she had amended patient records; there was no evidence she had fabricated those records; she had just transferred information into the clinical notes and sought to make them more accurate.

124. The DOH Guidance (paragraph 7.11) made it clear that the unsuitability category is reserved for criminal actions and matters of that sort, none of which formed the basis of the PCT's case against Dr Hadad. Professor Ikkos said in his report that Dr Hadad's behaviour could be characterised as acting in stupid ways.

125. This was a hearing de novo with more up to date evidence, particularly with regard to Dr Hadad's health. Removal would be disproportionate and should be replaced by contingent removal reflecting the conditions imposed by the IOP.

Consideration and Conclusions

126. We have carefully considered the written and oral submissions for both parties. We note that the facts are not disputed and all of the allegations are admitted.

127. We also wish to emphasise that we accept Dr Hadad's assertion that the diagnosis of cognitive impairment was incorrect. The initial NCAS occupational health assessment lead to a diagnosis of cognitive impairment because Dr Hadad was two points below the required standard in one discrete area. When Dr Hadad sought a second opinion from Dr Kapur, an independent Consultant Neuropsychologist, he rejected this diagnosis. In light of Dr Kapur's report we note that the PCT was satisfied that suspension was no longer necessary to protect members of the public or was otherwise in the public interest and it revoked Dr Hadad's suspension. We also note that Counsel for the PCT made it clear that the PCT did not make Dr Hadad's health any part of its case.

128. We first considered Dr Hadad's ground of appeal that that no or insufficient regard was paid to the decision of the GMC IOP, which was reached upon the same set of facts, and which determined to impose conditions on her registration rather than suspend her. However, we consider the GMC is a separate body with a distinct and different role. An IOP makes no findings of fact in relation to the exercise of its powers. We accept Mr Parker's evidence that the PCT's role is to make findings of fact and, where appropriate, to impose a sanction and that the PCT is responsible for managing the delivery of NHS services within its locality and has to make its own decisions as to the suitability of GPs who perform those services.

129. We next considered whether the PCT Panel had had no or insufficient regard to the opinion of Dr Heatley that Dr Hadad should be permitted to remain on the Performers List and complete her retraining. We were impressed that Dr Heatley gave evidence seeking one last chance for Dr Hadad despite knowing all that had happened. He told us that he did not consider she represented a danger to patients, that she was a competent doctor and enthusiastic about the practice of medicine and the care of her

patients. She had been undertaking supervised sessions at his practice and he and his partners were happy with her work, she had received positive feedback and they would be happy to employ her as a locum. However, we consider that Dr Heatley's evidence, whilst relevant, has to be considered and balanced alongside all of the other evidence we have seen and heard.

130. We then considered whether this appeal also extends to the issue of Dr Hadad's competency. We note the conclusions of the NCAS assessors that Dr Hadad's clinical performance was poor in three areas and her practice was inconsistent in seven areas. We also note that Dr Hadad was unwilling to accept the findings of the NCAS assessors in relation to her performance; when challenged that her suspension was not just based on her misdiagnosis but also on areas of poor performance, Dr Hadad disagreed and said that it was. She told us the NCAS assessment had indicated some clinical issues but they weren't a big deal and that Dr Heatley couldn't find the same issues flagged by NCAS. We noted Dr Heatley's evidence in this regard that as the supervision process evolved he did not think the clinical issues raised by NCAs or the OOH complaints were a problem and he was not concerned about Dr Hadad's clinical performance. He told us that with regard to the mismatch in terms of clinical performance between what NCAS found and he had found, he thought Dr Hadad may have been very stressed by the NCAS assessment and she may not have performed as well as she could. He also thought the NCAS report could have highlighted deficiencies which Dr Hadad had thought about, understood and put right. However, we note Counsel for the PCT confirmed that the issue of Dr Hadad's competency was only at issue in this appeal as background as there were no patient records in the evidence, and complaints were not part of the PCT's case in relation to her suitability. Accordingly, in considering the grounds of unsuitability and/or inefficiency we have restricted ourselves to considering the issues of lack of insight, honesty and integrity raised by the PCT in relation to Dr Hadad's breaches of the PCT's suspension and the GMC conditions.

131. The PCT removed Dr Hadad on grounds of both efficiency and suitability and we accept there can be overlap between these grounds. However, we thought it was equitable to consider them separately and as if distinct where possible, as otherwise one would add little or nothing to the other. Accordingly, we first considered whether Dr Hadad was unsuitable to be included on the Performers List.

132. The first allegation admitted by Dr Hadad was that she had worked in contravention of a PCT suspension. Dr Hadad was suspended from 6th May until 6th August 2010. We note and sympathise that the time lag between the initial misdiagnosis of cognitive impairment leading to her suspension and the PCT lifting the suspension allowed Dr Hossain to terminate their partnership agreement and plunged Dr Hadad into difficult financial circumstances. However, we note that during this period Dr Hadad worked a total of 59 sessions at Acorn.

133. Dr Hadad also admitted repeatedly breaching several of her IOP conditions (see paragraph 15 b) to f) above). She told us she had been stupid and naive and she would never behave in such a way again and that if conditions were placed on her on a contingent removal she would abide by them. She said she had acted unprofessionally and she was ashamed and embarrassed. She had compounded her breaches as she had

felt unable to tell anyone at all about her work at Acorn, not even close friends, .and so she had not told the PCT, the GMC, Dr Heatley or even her own GP, Dr Munro, when she obtained a sickness certificate from her. She told us it was not the case that she had no respect for the regulator, she was very stupid and regretted what she had done, but at the time her judgment was wrong and she wasn't thinking properly. Dr Hadad denied she regarded her own view of her capabilities as trumping the GMC's view, but she told us her work at Acorn was her only source of income, and the only thing keeping her alive. She told us she did not consider she was potentially putting patients clinically at risk but acknowledged she was risking their trust in the profession and putting patients at risk in her conduct as a professional.

134. We note that Dr Hadad did not attempt to own up to her persistent deceitful behaviour at any stage, even denying she had been working at Acorn when initially challenged by Dr Heatley. On the same day as the GMC hearing on 10th June 2010 when the IOP imposed conditions which, inter alia, prevented Dr Hadad from doing locum work, she went straight on to a locum session at Acorn and when she had a further hearing on 13th August 2010, at which her conditions were varied to allow her to do seven sessions per week at Stanhope (including locum sessions) and one session per week at the Cheshunt Community Hospital, she undertook another locum session at Acorn the following day.

135. We further note that Dr Hadad only owned up to what she had done when she was found out by Dr Birley, when he conducted a routine review of the current registration status of all doctors working at Acorn, from which he discovered Dr Hadad's registration was subject to the GMC conditions.

136. We are also concerned that Dr Hadad dissembled in her evidence relating to what she had told Dr Rasooly. Counsel submitted Dr Hadad's breach of conditions when applying to work for Dr Rasooly was technical and that she had informed both Dr Rasooly and Dr Heatley of her conditions and she may have been under the misapprehension that Dr Heatley would inform the GMC. Dr Hadad told us that she had been up front with Dr Rasooly, informing Dr Heatley she was going to see him and telling Dr Rasooly what had happened at Stanhope and about her GMC conditions However, we were concerned that when asked, Dr Hadad initially said she could not remember if she had told Dr Rasooly about her locum sessions at Acorn, but when pressed she conceded she almost certainly did not tell him, because she was unable to tell anyone about this.

137. We are further concerned that Dr Hadad had obtained a sickness certificate from her GP in between working two sessions at Acorn and that she had continued to do locum sessions at Acorn throughout the period of this certificate.

138. We also feel that Dr Hadad did not properly appreciate the inappropriateness of amending records retrospectively without making it clear that she was making later amendments. The PCT evidence was that when the PCT had decided to review Dr Hadad's patient records following the NCAS report, it had found 31 out of 71 records

reviewed had been amended more than three days post consultation. There were 41 amendments, 34 of which were made on 13th, 15th, 16th and 17th December 2009, just before the NCAS assessment. Dr Hadad told us that she was only adding information about tests she had requested or referrals she had made or codes for confirmed diagnoses and that she was not fabricating entries. She denied it was to make her look better to NCAS. We noted Dr Heatley's evidence that his impression was that Dr Hadad was aware some of her records were very scanty and she wrongly went back and amended them, but based on what she said she was embellishing and polishing rather than seeking to mislead. However, we consider Dr Hadad was seeking to justify and minimise her actions and her reasoning in so doing demonstrated a serious lack of insight.

139. Counsel for the PCT referred us the DOH Guidance which states that suitability can be relied on where there is a lack of tangible evidence of a doctor's ability to undertake the performer role, for example, essential qualities. He also pointed out the relevant sections of Good Medical Practice which he submitted Dr Hadad had breached and he submitted trust was at the heart of any relationship of any medical professional and her regulator, colleagues and patients.

140. Counsel for Dr Hadad submitted the PCT was required to exercise its powers in a proportionate way, compatible with the principles of natural justice. The sanction had to be proportionate and a decision that Dr Hadad was unsuitable leading to mandatory removal would be disproportionate. She contended the IOP determination on 7th March 2011 when conditions had been imposed had been a full review with knowledge of all the circumstances and the Tribunal should impose contingent removal with conditions. She told us this case warranted special treatment because of the very difficult circumstances in which Dr Hadad found herself, which were very strong mitigation for the decisions Dr Hadad had taken. She said Dr Hadad's evidence before us was full and frank in accepting she had made very poor choices and she had shown a good level of insight that she should not have made those choices. She also said Dr Hadad had been very clear that she would abide by any conditions placed on her in the future, as demonstrated by her having complied with the GMC conditions placed on her as regarded her latest appointment when she had notified the PCT, the GMC and her supervisor.

141. We have taken all of the above into account. We note all of the supportive feedback and testimonials, including Dr Rasooly's current view that Dr Hadad is a doctor of great integrity, and extremely dedicated to her work and her patients and we are satisfied that Dr Hadad is a very articulate, highly qualified practitioner.

142. This part of the hearing was considered in private

143. We are concerned that Dr Hadad imposed her own standards in preference to those of the PCT and the GMC and put her own interests before those of everyone else, thinking she knew better than her professional regulator and her contractual employer. Whilst we accept that the circumstances of her suspension and the consequences which flowed from it were most unfortunate, as a member of a profession which the public holds in high regard, she was obliged to abide by the decision of the PCT; if

she felt it was unfair she should have sought redress through the proper channels rather than taking matters into her own hands. In light of her repeated and protracted breaches of her PCT suspension and her GMC conditions we consider Dr Hadad exhibited persistent unprofessional behaviour; and it was simply not sufficient to say she had been stupid and naive and she would never do it again. Nor are we persuaded that by informing the PCT, the GMC and her supervisor of her latest appointment, she had demonstrated good insight and she should not be characterised as having lack of insight. Dr Hadad is not a young trainee but a mature doctor who failed to come clean and admit to what she had done. We cannot condone protracted and repeated deceitfulness; it was only when she was left with no alternative when her deceits were discovered, that Dr Hadad admitted what she had done, and even then she initially lied to Dr Heatley when he first challenged her.

144. Given that Dr Hadad failed to demonstrate at any stage that she had sufficient insight, honesty and integrity, we consider we have no alternative other than to find that she is unsuitable to be included on the PCT's Performers List.

145. Given our finding of unsuitability we briefly considered the issue of inefficiency. We consider the issues of insight, honesty and integrity go to unsuitability rather than inefficiency. However, we accept that Dr Hadad's conduct meant the measures put in place by the PCT had been rendered pointless and ineffective and the PCT had therefore wasted resources in taking steps which Dr Hadad had disregarded. We also accept the PCT's submission that given the duration and persistence of dishonesty and lack of insight and integrity, the PCT could not be confident that Dr Hadad would abide by any further measures to monitor or supervise her work. Accordingly, we consider that Dr Hadad's continued inclusion in the Performers List would be prejudicial to the efficiency of services and even if we had not found her to be unsuitable, contingent removal would not satisfy the breadth and depth of the fundamental deficiencies displayed by Dr Hadad on the admitted facts.

Decision

146. For all of the above reasons it is our unanimous view that Dr Hadad should be removed from the PCT's Performers List on the ground of unsuitability and inefficiency pursuant to regulations 10(4)(a) and (c) of the National Health Services (Performers List) Regulations 2004

147. Accordingly, we dismiss the appeal by Dr Hadad against the decision of the PCT on 27th April 2011 to remove her from its Performers List.

148. We have not been invited to consider National Disqualification but have a duty to consider that. We would not do so without giving the parties the opportunity to make submissions. Accordingly, we direct that this issue is dealt with pursuant to Regulation 18A of the National Health Services (Performers List) Regulations 2004

149. The parties are hereby notified of their right to appeal this decision under Section 11 of The Tribunals Courts and Enforcement Act 2007. 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

Dated this 15th day of August 2011

…………………………………..
Debra R Shaw
First-tier Tribunal Judge on behalf of the Tribunal