Primary Health Lists

Dr Andrew Gilbey

V

Abertawe Bro Morgannwg University Local Health Board

[2012] PHL 15458

Before

Judge Nancy Hillier
Dr Sati Aryanagam
Mrs Sue Last

Hearing
28 – 31 May 2012 Swansea Civil Justice Centre.

Dr Gilbey represented himself. The Respondent was represented by Jeremy Hyam of Counsel. Dr Jane Harrison, Dr Gerry O'Dwyer, Mrs Hilary Dover, Professor Malcolm Lewis and Dr Gilbey gave oral evidence.

DECISION

Appeal

1. Dr Gilbey applies to this Tribunal pursuant to NHS (Performers Lists)(Wales) Regulations ("The Regs") Regulation 15(6) for the revocation of the contingent removal, or variation of conditions of contingent removal, imposed upon him by way of a Consent Order made on 26th August 2011 made compromising his application for revocation of contingent removal conditions imposed on him by the FHSAA in 2008/2009 in case numbers 14620 and 15052.

Background

2. From 1 April 1998 Dr Gilbey worked at and developed the Cwmllynfell Practice and undertook some hospital and out of hours work. Following a complaint made against him in July 2006 by the manager of a nursing home an enquiry was carried out by the medical director of Bridgend Local Health Board (LHB). It was eventually agreed that Dr Gilbey would undergo an NCAS assessment. An NCAS assessment was undertaken covering occupational health, behaviour and clinical skills and a draft report dated 24 September 2007 was prepared. The report identified 6 areas of inconsistent performance:

    - Use of resources
    - Patient communication
    - Respect and trust with patients
    - Leadership and management
    - Sharing information with colleagues
    - Maintaining performance

    and 8 areas of unsatisfactory performance:

    - Assessment of patient condition
    - Examination technique
    - Management of patients
    - Infection control
    - Prescribing
    - Record keeping
    - Obtaining consent
    - Keeping up to date

3. The report concluded that Dr Gilbey should not practice independently until he had successfully completed a period of targeted, monitored and supervised re-training of up to 12 months. NCAS also recommended that Dr Gilbey be placed with an advanced training practice (ATP) to be arranged by the Welsh Deanery and that he should be supported by coaching sessions to assist with inter-personal skills. Dr Gilbey was suspended from the performers list on 4 September. Dr Gilbey made written representations to NCAS about factual errors in the report which was finalised on 25 September.

4. On 10 January 2008 the suspension was lifted and Dr Gilbey was contingently removed from the performers list subject to the condition that he undertook a 6 months training placement at an ATP. A placement at Old School Surgery, (OSS) Pontyclun commenced on 4 February. The placement ended on 23 April 2008. On June 10 the LHB wrote to Dr Gilbey under the National Health Service (Performers Lists) (Wales) Regulations 2004 (the Regs) informing him that he would be removed from

the list because he had not complied with the condition of retraining imposed on 10 January.

5. On 2 July 2008 Dr Gilbey appealed the decision of June 10 to the FHSAA. That appeal was heard in December, with a decision given on 8 December that the FHSAA upheld the contingent removal. At paragraph 81 of the decision the panel concluded that they were satisfied as to shortcomings in Dr Gilbey's clinical skills, communication difficulties and behavioural problems and they were satisfied that an "efficiency case" was proved. The panel concluded that Dr Gilbey should be contingently removed subject to 4 conditions setting out a placement at an ATP. Dr Gilbey then applied to the FHSAA for a condition to be added requiring the LHB to fund locums at his practice. That application was due to commence on 2 March 2009. On 2 February the LHB informed Dr Gilbey that the Deanery had been unable to find a suitable ATP placement for him. On 26 February Dr Gilbey's legal representative informed the LHB that Dr Gilbey would also ask the FHSAA to vary the condition requiring the placement to take place at an ATP, suggesting that Dr Gilbey could undertake training with a Dr Goodwin.

6. Dr Gilbey was referred to the General Medical Council (GMC) and was assessed on the basis of his fitness to practice (FTP) on 6- 15 January 2009.

7. The FTP assessment report recorded that Dr Gilbey's professional performance was "unacceptable" in the following areas:

    - Assessment of patient's condition
    - Providing or arranging treatment
    - Record keeping
    - Working with laws and regulations
    - Relationships with colleagues/GPs/teamwork

    and that it was a "cause for concern" in respect of:

    - Constructive participation in audit, assessment and appraisal
    - Communication with patients, listening to patients, respecting their views and providing comprehensible information
    - Respect for patients, politeness, respect and confidentiality including respecting patients' rights to decline treatment.

8. The FHSAA hearing took place on 27 March 2009. The decision records at paragraph 18 that Dr Gilbey accepted the criticisms made of him in the NCAS report and that he had designed a programme of retraining which would remedy the defects. The panel determined that the contingent removal conditions should be varied to reflect this retraining package, removing the requirement of an ATP placement. The LHB appealed the decision to the High Court. The decision was upheld by Wyn Williams J on 3 July 2009.

9. In the interim there was a further FHSAA hearing which concluded on15 May. That hearing was concerned mainly with the condition of a further NCAS assessment.

10. On 22.7.09 Dr Gilbey gave notice on his GMS contract and in the September he took up a post as a Senior House Officer at Bronglais General Hospital, Aberystwyth (Bronglais).

11. The GMC FTP Panel considered Dr Gilbey's case from 28 June to 7 July 2010 on the basis of the recommendations made by the January assessment. The Panel concluded that Dr Gilbey's fitness to practice was impaired by reason of deficient professional performance and imposed conditions on his registration for a period of 1 year. By these conditions Dr Gilbey's day to day work had to be supervised by a consultant or equivalent and he was to have a mentor, Dr M Williams. In addition, Dr Gilbey was to work with a Postgraduate Dean or Director of Postgraduate General Practice Education in formulating a Personal Development Plan (PDP). Professor Malcolm Lewis agreed to work with Dr Gilbey on the PDP.

12. In August 2010 Dr Gilbey obtained a 1 year locum appointment in a supervised training posts at Foundation Year 2 level. He completed general medicine and trauma and orthopaedic surgery rotations at Bronglais and then moved to a general practice rotation in Lampeter on 6 April 2011. This ended in May 2011. The FHSAA conditions of May 2009 were never complied with as Dr Gilbey failed to find a suitable supervisor.

13. On 1 May 2011, Dr Gilbey issued an application to revoke the FHSAA conditions of 30 March and 15 May 2009 on the basis that the GMC conditions were sufficient to ensure he could practice safely as a GP. The Respondent sought the advice of the Deanery and was informed that the steps taken by Dr Gilbey between 2009-2011 were insufficient to address the identified deficiencies and that in any event since any doctor who had not actively practiced as a GP for 2 years or more should undergo assessment, take the Applied Knowledge Test (AKT) and complete a Returner Placement, he was not in a position to simply return to practice.

14. The LHB proposed to Dr Gilbey that the following should take place:

    - A further assessment to establish what his ongoing educational and remedial needs were.
    - A placement in an ATP for a period equivalent to at least 6 months on a full time basis.
    - An AKT or equivalent assessment.

15. Dr Gilbey suggested that a compromise meeting should be convened which took place on 5 July 2011 following which an action plan was drawn up. Shortly afterwards an ATP, Pontcae Surgery in Merthyr Tydfil, indicated an interest in providing the placement., and confirmed that as a clear intention on 19 August 2011. The action plan was turned into a draft

consent order which set out an agreed set of conditions to be substituted for the FHSAA conditions of 30 March and 15 May 2009 and an agreed consent order was submitted to the Tribunal and approved on 26 August.

16. The GMC reviewed Dr Gilbey's conditions in July 2011. The conditions were renewed in broadly similar terms and will be reviewed again in July 2012.Dr Gilbey was conditionally included on the Bristol PCT Performers list on 21 September 2011. This was subject to retraining conditions and was not pursued by Dr Gilbey.

17. From August 2011 to January 2012 Dr Gilbey worked in a locum post as a Senior House Officer in the LHB's orthopaedic service, providing triage in A&E at Morriston Hospital., Swansea He now works in an orthopaedic triage position at the Princess of Wales Hospital in Bridgend.

18. The Deanery assessment took place on 13 October 2011. The Deanery received the results a week later and they were sent to both Dr Gilbey and Pontcae. Following consideration of the report at a partners meeting the offer of a training placement for Dr Gilbey was withdrawn and subsequent enquiries by the Deanery revealed that it was unlikely that an alternative placement at an ATP could be found.

19. Dr Gilbey made an application to revoke or vary the August 2011 conditions on 27 January 2012, and the LHB responded on 22 February, indicating their opposition to the application. Directions were given to a contested hearing.

Law

20. The NHS (Wales Act 2006 s 49(1) provides:

> *Persons performing primary medical services*
> *(1)Regulations may provide that a health care professional of a prescribed description may not perform any primary medical service for which a Local Health Board is responsible unless he is included in a list maintained under the regulations by a Local Health* Board*.*

21. The relevant regulations are the NHS (Performers Lists) (Wales) Regulations 2004. Regulation 15(6)(a) provides that where a contingent removal is imposed a performer may apply to the Tribunal for revocation of the contingent removal, variation of conditions or revocation of conditions. Under Reg 16(b) the LHB may remove a performer who has not complied with the conditions. The LHB in this case has not removed Dr Gilbey from the list.

22. The burden of proof is on the applicant, Dr Gilbey, to demonstrate on a balance of probabilities that the contingent removal should be revoked or that the conditions should be varied or revokes.

Preliminary matters and applications.

23. At the commencement of the hearing Dr Gilbey made an application for late evidence to be admitted. The application was not opposed. The evidence consisted mainly of emails and communications which were potentially relevant to the application and we agreed to admit them.

24. Following questions put by Dr Gilbey to Hilary Dover, Mr Hyam applied for disclosure of the recommendations made by the GMC FTP assessors to the FTP panel. Dr Gilbey had suggested that the recommendations of the assessors were not followed by the GMC panel as to a placement in an ATP. Mr Hyam submitted that it was therefore a relevant document in the hands of Dr Gilbey and that it should be disclosed. Dr Gilbey stated that he opposed disclosure of the document because he did not want it to be used as evidence against him. He claimed that the panel were not entitled to consider the assessment without looking at the evidence behind it in detail which he estimated would take 8 days.

25. The panel considered the application and the submissions made on behalf of both parties. We applied the overriding objective and the need to avoid unproductive delay. We refused the application, on the grounds that it would not be fair or just to admit it, especially since the Respondent had had ample prior opportunity to apply for disclosure of the document and had not done so. Further, we did not feel that an in depth examination of the recommendations would be relevant to the scope of this hearing. Dr Gilbey accepted that the recommendations included a recommendation that he attend an ATP, a recommendation which was not imposed by the GMC. We also decided that the admission of the document could potentially cause prejudice to Dr Gilbey at a very late stage in the proceedings and could give rise to a disproportionate delay to the hearing. There was no prejudice to the Respondent caused by the refusal of the application, since Mr Hyam could cross examine Dr Gilbey on the point or make submissions on it if it were relevant to do so.

26. Following the evidence of Professor Lewis which completed the Respondents' evidence and the overnight adjournment, Dr Gilbey made an application on 30 May for us to admit further written evidence into the proceedings. This consisted of email correspondence which was concerned with the receipt and onward transmission of the October 13 2011 assessment by the Deanery. Professor Lewis had given evidence that he had not read the assessment until after the withdrawal by Pontcae Surgery (Pontcae) of the offer of a training placement to Dr Gilbey in November 2011. The emails suggested that he may have read them at the time of receipt.

27. Mr Hyam objected to the admission of the evidence since the emails had not been put to Professor Lewis and because the emails did not necessarily show when the documents had been read, only when they had been received.

28. Dr Gilbey submitted that he was confused about what the hearing was about. He said that he felt that Professor Lewis was being given credence as an “expert” and that the documents were relevant to his case because they showed that Professor Lewis had not done enough for him in putting together a training prescription.

29. We considered the submissions made and the overriding objective, and decided to admit the evidence, although we expressed doubts as to its potential relevance to the decision we were being asked to take. We could not identify any prejudice to the Respondent in the admission of the documents. We gave both parties time to consider whether they wished to ask for Professor Lewis to be recalled, but neither made an application.

30. It was agreed at a case management hearing that the LHB would present its evidence to the panel before Dr Gilbey gave his evidence so that he could comment upon it in his own evidence. Dr Gilbey was offered regular opportunities for breaks to ensure he had adequate time to reflect on the evidence given by each witness prior to questioning them. Judge Hillier took Dr Gilbey through his evidence in chief to ensure he had an opportunity to present his case and to give evidence on all relevant issues. Dr Gilbey had a supporter sitting with him during the hearing. Both parties had an overnight adjournment to consider their closing remarks.

Issues

31. The panel identified the following issues arising from the hearing:

    Whether the contingent removal embodied in a consent order on August 26 2011 should be revoked?

32. Dr Gilbey’s primary application is for the consent order contingent removal to be revoked, thus leaving him on the Performers List without conditions. The LHB have not taken any action to remove Dr Gilbey from the list due to non compliance with the conditions.

    Whether the current conditions as agreed in the August 26 2011 consent order should be revoked?

33. Dr Gilbey’s position is that it safe for him to return to GP practice under the conditions imposed by the GMC, that his remediation needs have been addressed and that there is no need for any further requirements. The LHB position is that Dr Gilbey has not addressed his remediation needs, which are in their view significant. They also submit that he has not undertaken a successful GP placement in over 4 years, therefore nothing less than the current conditions will suffice.

    Whether the current conditions as agreed in the August 26 2011 consent order should be varied? If so, what should they be varied to?

34. The LHB position throughout was that no condition less than the requirement of placement at an Advanced Training Practice would suffice. Dr Gilbey did not put forward any alternative conditions until his closing submissions when he suggested that we could require him to work in a salaried position or in an out of hours placement or drug rehabilitation position.

Whether, in the event that the current conditions are not revoked, Dr Gilbey should be removed from the list by the Tribunal as the conditions are unlikely to be fulfilled?

35. Dr Gilbey opposed removal from the list. The LHB did not put forward a positive case for removal, relying rather on the panel coming to its own conclusion. In Counsel's case summary the LHB mooted a possible extension to the time for compliance with the conditions to enable Dr Gilbey to secure a placement at an ATP or similar before the end of 2012.

Whether the Deanery assessment is a valid assessment of Dr Gilbey's training needs or is flawed.

36. The LHB submitted that the assessment performed was at a low standard (Y2 entry to GP specialist) but that it clearly demonstrated continuing shortcomings and was a reasonably accurate predictor of training needs. Dr Gilbey submitted that the test was inappropriate and unfairly administered.

Whether the tribunal is satisfied on the balance of probabilities that Dr Gilbey has addressed the deficiencies identified by NCAS, the FTP and the Deanery assessment.

37. The LHB case is that there is a core consistency between the NCAS assessment, the GMC assessment and the Deanery assessment of basic communication deficiencies and a lack of empathy and sensitivity. They point to the fact that the most recent assessment, in October 2011, demonstrates considerable deficiencies still remaining at a time when Dr Gilbey was actually placed in a GP training position, Dr Gilbey's case is that the NCAS assessment is flawed by factual errors, that the GMC assessment recommendations were not followed by the GMC FTP panel and that the Deanery assessment was an inappropriate test, unfairly administered. He states that he accepted the opinions expressed by the NCAS assessors and that he has addressed the issues of record keeping, communication and demonstrating empathy evidenced by the excellent current references provided to the panel.

Whether Dr Gilbey has demonstrated any insight into his training needs?

38. Dr Gilbey's position is that he has not sought to go behind the opinions expressed in the NCAS report and that he has been unfairly criticised for questioning the need for an advanced training practice at this stage because he has addressed the deficiencies which were identified. It is

submitted on behalf of the LHB that Dr Gilbey has continually sought to question and criticise the method of assessment rather than looking to the results of the assessment, taking on board the deficiencies demonstrated and taking advantage of training opportunities to assess them. The LHB position is that Dr Gilbey still demonstrates little insight into his deficiencies or training needs.

What are the current risks to the public of Dr Gilbey returning to be a GP without further training?

39. Dr Gilbey suggests that there are no risks to the public since the GMC conditions are imposed to address any risks. The LHB submit that the GMC conditions are designed to address the issue of fitness to practice rather than the specific position of GP, which is the LHB remit. They submit that there would be significant risks to the public from a GP who has remediation needs and has been away from practice to return to work as a GP without at least 6 months in an ATP which would not be met by the more remote supervision of Dr Gilbey required by the GMC.

Whether the LHB and the Deanery have either individually or together acted against Dr Gilbey's interests

40. Dr Gilbey feels that whilst Hillary Dover and Dr O'Dwyer had attempted to assist him, Professor Lewis and Dr Harrison amongst others had not done enough to assist him return to practice and had at times acted against his interests.

Whether Dr Gilbey has been unfairly prejudiced by the fact that he has had to criticise other doctors and the assessments he has taken in order to defend himself against the allegations made against him?

41. Dr Gilbey feels that he has been put in a Catch 22 situation, because he has considerable reservations about the assessment methods used to identify his deficiencies, and about standards in ATP's but if he raises concerns he is said to lack insight. The LHB accept that it is appropriate for Dr Gilbey to examine the assessment processes but states that he has taken a disproportionate stance resulting in almost his entire focus being on the inadequacies of others rather than his own deficiencies.

Whether there is an irreconcilable tension between the results of independent peer and patients' assessment and the current hospital references about Dr Gilbey's empathy and communication skills and the NCAS, GMC and Deanery assessment identifications of deficiencies in these areas.

42. Dr Gilbey submits that the tension is explained by deficiencies in the assessment process. He complained that the NCAS assessor had been briefed by the LHB, that the GMC assessor had trained the NCAS assessor, and that at the Deanery assessment Mary Beech, the Organisational Lead for GP Training at the School of Postgraduate Medical and Dental Education at Cardiff University had "entertained" the

assessors and remained in the room during the assessment. He described his interviews as intimidating. Dr Gilbey points to the assessment he undertook for Severn PCT where he undertook an English Deanery assessment and scored well, and the objective assessments by his peers and patients at the time of the NCAS assessment. In respect of the difference between the Severn PCT assessment and the Deanery assessment, the LHB submit that the tension is explained by the type of encounter involved, namely that the latter involved an encounter with real person which is a better way to address communication and empathy than a written test. The LHB concede that the current references are good but submit that Dr Gilbey is able to function far better in a supported hospital environment as part of a team but that the GP environment is very different and the failed placements demonstrate that that is where his weaknesses come to the fore..

Evidence

43. We heard evidence from Dr Jane Harrison who is Assistant Medical Director (Primary Care) for Abertawe Bro Morgannwg University (ABMU) Local Health Board. She advises on governance, quality and contractual issues, and is the clinical lead for pathway and service redesign for ABMU. She has nearly 25 years prior experience both as a GP principal and sessional GP. From 1998 to 2003 she helped to establish and lead an education and support network for sessional GPs across Wales and from 2003-2007 she was a Senior Medical Officer for the Welsh Assembly Government.

44. Dr Harrison was a member of the List Management Panel held by the former Neath Port Talbot LHB which took place on 9 June 2008 and which took the initial decision to remove Dr Gilbey from the Performers List.

45. Dr Harrison's evidence was that the September 2008 NCAS report identified 6 areas of inconsistent performance and a further 8 areas of unsatisfactory performance. In her opinion the deficiencies identified go to the heart of the skills and expertise required by a GP and "*all actions taken since the NCAS report have been directed towards remediating these deficiencies before Dr Gilbey can return to safe general practice. The importance within general practice of sound patient examination, assessment and management, excellent communication skills and good team working cannot be overstated in ensuring patient safety*."

46. Dr Harrison also referred to the deficiencies in performance identified by the GMC which she said were in some cases identical and in others very similar to those identified by NCAS 18 months before. She explained that the GMC assessment was not specifically concerned with Dr Gilbey's suitability to practice as a GP but rather with his ability to practice as a clinician in any role. In her view the compliance with the GMC conditions alone would be insufficient to provide the necessary reassurance to the LHB that Dr Gilbey could be allowed to safely return to general practice

without fulfilling additional conditions for further training, supervision and assessment. This is because the NCAS report identified specific remediation issues relating to the role of a GP which in the Respondent's view have not yet been addressed. She stated "*These issues require specific training within a general practice setting with careful observation, recording and feedback. Deficiencies in communication and problems with empathy, dignity and respect need to be addressed by trainers with specialist expertise as they can be particularly difficult to remediate*. "

47. Dr Harrison felt that the good references obtained by Dr Gilbey in a hospital setting are encouraging but in her view there is a considerable difference between working in a relatively junior role in a hospital, with all of the support that is available in that environment, and working in general practice where the practitioner is, by and large, working in isolation. She pointed out that a GP" … *is presented with a very wide range of clinical, psychological and social conditions and will usually not know what advice the patient is seeking prior to consultation. Indeed, advice can be sought on a number of issues in a single consultation and it is this complexity within general practice that sets it apart from other clinical disciplines such as orthopaedics. It is for this reason that general practice requires much greater skills in terms of patient assessment, communication and empathy which are, unfortunately, the very areas in which Dr Gilbey has been found deficient. Success in a hospital setting is, therefore, not an automatic indicator of success in general practice and this is reflected in the specific training requirements for GPs.* "

48. Dr Harrison's evidence was that when Dr Gilbey issued an application in 2011 to revoke the FHSAA conditions of 30 March and 15 May 2009 the Deanery advised that the steps taken by Dr Gilbey between 2009-2011 were insufficient to address the ongoing concerns regarding his ability to practice safely as a GP and that any GP who has not actively practiced for 2 years or more should in any event undergo assessment, take the RCGP's Applied Knowledge Test (AKT) and complete a Returner Placement. The LHB had determined that a placement in an ATP for a period equivalent to at least 6 months on a full time basis was necessary to provide the detailed observation and development of Dr Gilbey's skills and practice which were needed before he could be allowed to return to independent practice.

49. Dr Harrison attended the meeting on 5 July 2011 to discuss the way forward to assist with the clinical perspective. She stated "*I sought to help Dr Gilbey understand the difference in the focus and function of the GMC conditions as opposed to the Performers List functions exercised by the LHB and FHSAA. I explained that it was my view that an ATP was essential to provide the in-depth remediation which Dr Gilbey required because it is only ATPs that have the necessary skills and experience required to help GPs turn around long established behaviours. I recognised that Dr Gilbey's experience of an ATP had not been a happy one, but wanted to stress that a similar practice was the most appropriate environment for him to achieve his goal of returning to independent*

practice. I was concerned that if Dr Gilbey did not take up a placement with an open mind, then he could face further difficulties." She noted that the assessment part of the package agreed was to be undertaken by assessors from outside Wales to ensure impartiality.

50. Dr Harrison's statement records Dr Gilbey's October 2011 assessment results as follows:

A. Machine marked clinical acumen test. Dr Gilbey scored 135 out of 150 (90%)

B. A simulated patient encounter and written problem solving test.

		Assessor 1	Assessor 2
Simulated patient encounter	Empathy and sensitivity	2	2
	Communication skills (verbal and non-verbal)	3	2
	Professional integrity	2	2
Written problem solving test	Communication skills (written)	2	2
	Empathy and sensitivity	2	1
	Conceptual thinking and problem solving	1	1
	Professional integrity	2	2

The standards are:

1. The applicant is unlikely to attain an adequate level of proficiency by the end of a standard period of induction.
2. The applicant will need to improve significantly to become proficient by the end of a standard period of induction.
3. With focussed effort, the applicant will likely be proficient by the end of a standard period of induction.
4. The applicant will likely be highly proficient by the end of a standard period of induction.

51. Dr Harrison concluded that the assessment identified very similar issues in respect of deficiencies in Dr Gilbey's skills and practice to those identified by the NCAS report and GMC assessment. She stated "*It was clear to me that there continued to be a need for intensive remediation before the LHB could be reassured that Dr Gilbey was capable of safe, independent practice within a general practice setting, as previously explained. The deficiencies were clearly consistent and persisting, being reflected in each assessment undertaken by different professional agencies, and reinforced the need for expert retraining.*"

52. Dr Harrison described the outcome of the extensive attempts made to find an ATP to carry out the necessary retraining and the withdrawal of the offer by Pontcae as "*disappointing*". The LHB had tried to assist by provided Dr Gilbey with details of the schemes run by other Deaneries and stating that the LHB was prepared to agree to allow Dr Gilbey 12 months in which to try and secure an alternative placement.

53. We heard evidence from Dr Gearoid (Gerry) O'Dwyer, a partner at Pontcae Surgery in Merthyr Tydfil. He described Pontcae as a 4 partner practice with 2 salaried GPs. It is part of the Welsh Deanery's ATP network, as well as being a GP training practice, providing training to Foundation Year 2 students and those undergoing GP specialty training. Dr O'Dwyer is the lead for those doctors who receive ATP training within the practice.

54. Professor Malcolm Lewis and Dr O'Dwyer told the panel that the ATP network was set up by the Deanery in 2003 and Pontcae had been part of the network from the start. The purpose of the ATP placement is to provide a practitioner in difficulties with the support and training necessary to achieve the objectives identified by NCAS within a practice setting.

55. Dr O'Dwyer's statement records that in order to become a GP trainer the prospective trainer must complete a three module preparatory course which includes elements dealing with teaching and supervision. All trainers and their practices are inspected upon initial application by a team of three independent experienced GP educators. All GP trainers are required to participate in ongoing educational update sessions which take place ½ day every month and advanced trainers must also attend twice yearly residential meetings of the ATP network where developmental activities focused on helping established GPs in difficulties are undertaken.

56. Dr O'Dwyer explained that since 2003 Pontcae has provided 4 ATP placements to GPs who have required remediation training. The Practice is under no obligation to offer a placement to any GP and can opt to withdraw from the process at any time before, and even during, a placement.

57. In summer 2011 the Deanery made a request for an ATP placement to which Pontcae responded as it had no ATP commitments at the time. Dr O'Dwyer was provided with the NCAS assessment and the GMC conditions which he discussed with his partners and it was agreed that Pontcae was prepared to consider offering Dr Gilbey a placement.

58. In October 2011 Dr O'Dwyer received the assessment results from the Deanery He stated "

> *The partners at Pontcae considered Dr Gilbey's history and the available assessments. There was a general discussion as to whether it was felt that the practice could manage him. The scores for the written problem solving and simulated patient encounter tests in the*

Deanery assessment indicated that the difficulties with Dr Gilbey stemmed from personality and behavioural issues, rather than clinical ability. Dr Gilbey's comments as recorded in the Deanery assessment, as well as an overview of his background generally, indicated a concerning lack of insight into the deficiencies in his practice and the work that would be required to try and address them. A lack of insight affects the application of clinical knowledge and will seriously limit the effectiveness of any remediation provided. Behavioural and personality issues are very difficult to change in any circumstances, but the partners considered that the nature of Dr Gilbey's deficiencies, coupled with a lack of insight, raised significant concerns that a placement would be unworkable and unsuccessful. "The partners were also aware that the placements at OSS and Lampeter had not been successful.

59. Dr O'Dwyer explained that although the Practice Manager had expressed reservations about Dr Gilbey, the Partners were the ones who made the final decision and that was to withdraw the offer of a placement. The Deanery had not influenced their decision, nor had the LHB.

60. We heard evidence from Ms Hilary Dover, the Locality Director for the Neath Port Talbot (NPT) Locality within the LHB whose role and responsibilities include management of primary care, hospital and community services in the NPT Locality.

61. Ms Dover explained that there had been some concern, raised by the practice, that Dr Gilbey was acting in breach of the FHSAA conditions of 30 March and 15 May 2009 and the NHS (Performers List) (Wales) Regulations 2004 in taking up the post in Lampeter when he was subject to conditions preventing him from undertaking general practice save under specific supervision requirements. The LHB had sought the advice of the Deanery and had been told that the nature of the post at Lampeter was so junior and sufficiently far removed from independent general practice and/or specialty general practice training, that there was no requirement for the post-holder to be on a Performers List. The LHB was also reassured that Dr Gilbey would be supervised whilst in post.

62. The LHB had learned that in mid 2010, Dr Gilbey had applied to work for the Avon Primary Care Support Agency which provides administrative support to primary care services for NHS Bath & North East Somerset, NHS Bristol, NHS North Somerset and NHS South Gloucestershire. He was conditionally included in Bristol PCT's Performers List subject to adhering to his GMC conditions and completing the Severn Deanery GP Induction and Refresher Scheme assessment. Depending on the outcome of this assessment, Dr Gilbey would be required to complete the Severn Deanery GP Induction and Refresher Scheme or would have to resign or be removed from the Bristol PCT Performers List. Dr Gilbey declined to go through the Severn Deanery GP Induction and Refresher Scheme and resigned from the Bristol PCT Performers List.

63. Ms Dover explained that Dr Gilbey had written to the LHB in early 2011 asking it to revoke the FHSAA conditions of 30 March and 15 May 2009 on the grounds that any public interest issue had now been addressed by the GMC conditions. A meeting took place on 5 July 2011 which she attended and where Dr Gilbey was given the opportunity to fully present his case. He proposed that the LHB abide by the GMC conditions and not seek to impose secondary conditions in order to assist him in achieving his goal which was to have the option of returning to independent general practice, if he wished to. Ms Dover stated that she explained to that meeting on behalf of the LHB that their key concern was to ensure patient safety, which was why there was a need for Dr Gilbey to demonstrate competence and an ability to safeguard patients. In Ms Dover's view it was agreed that, by following a programme largely based on a returner GP training programme, Dr Gilbey's identified remediation areas according to NCAS, the GMC and as a GP who had been out of practice for several years would all be addressed.

64. Ms Dover stated "*The meeting was, at times difficult, but very useful in terms of allowing all of the parties to discuss issues fully and openly. I felt reassured by the end of the meeting that progress had been made*."

65. Ms Dover also explained that by 17 August 2011 the LHB had been able to agree a funding package whereby they agreed to pay an education grant for the duration of the placement, which Dr Gilbey would use to fund his 50% share of the training costs, the Deanery's administrative fees and the fees of the occupational psychologist. Having made these payments, Dr Gilbey would then receive the remainder as an 'income'.

66. Ms Dover received a letter from Dr Gilbey dated 30 January 2012 asking that the LHB fund the AKT which was to have taken place at the end of the assessment and occupational psychology sessions which were to have supported him during placement. It was felt that these matters were components of an overall package including the placement at an ATP.

67. On behalf of the LHB Ms Dover stressed that Dr Gilbey has been contingently removed from the Performers List since January 2008 and stated "*during that time has been subject to four different sets of conditions, all intended to provide Dr Gilbey with the in-depth supervised training which is necessary to allow him to return to safe general practice. It has not been possible for Dr Gilbey to fulfil any of those sets of conditions. Considerable time and resources have been devoted to seeking to return Dr Gilbey to general practice, to no avail."*

68. Professor Malcolm Lewis, the Director of Postgraduate General Practice Education for Wales, based at the Postgraduate Medical and Dental School of Cardiff University represented the Deanery at the Tribunal hearing. He has been in the post for 10 years and is responsible for all aspects of the work of the GP section of the Deanery including speciality training programmes for around 136 GP trainees per year, appraisal and

continuing professional development for all 2700 GPs in Wales and the Deanery's ATP network which he set up in 2002.

69. Professor Lewis records in his statement the findings of the GMC performance test held between 6-15 January 2009. Dr Gilbey's professional performance was found to be unacceptable in the following areas: Assessment of patient's condition; Providing or arranging treatment; Record keeping; Working with laws and regulations and Relationships with colleagues/GPs/teamwork. His assessment recorded a cause for concern in respect of: Constructive participation in audit, assessment and appraisal; Communication with patients, listening to patients, respecting their views and providing comprehensible information; Respect for patients, politeness, respect and confidentiality including respecting patients' rights to decline treatment. He states"Dr Gilbey also scored poorly in certain domains of the Simulated Surgery test and the Observed Structured Clinical Examinations." At the FTP panel in June of that year Professor Lewis comments that the panel concluded that Dr Gilbey's fitness to practice was impaired by reason of deficient professional performance and imposed conditions on Dr Gilbey's registration for a period of 1 year. Under those conditions Dr Gilbey's day to day work had to be supervised by a consultant or equivalent and he was also to have a mentor and was to work with a Postgraduate Dean or Director of Postgraduate General Practice Education in formulating a Personal Development Plan. Professor Lewis highlighted the fact that when the case was reviewed by the GMC in July 2011 there were outstanding deficiencies in Dr Gilbey's performance in respect of inter-personal skills and that there had been lapses in performance so a further 12 month period of conditional registration was imposed by the GMC.

70. Professor Lewis stated:"*The GMC's conditions are concerned with addressing deficiencies in Dr Gilbey's ability to practice as a doctor generally. Although many of the issues identified during the January 2009 assessment would be relevant to any area of practice, they are of particular concern when viewed in the context of general practice. This is because general practice poses particular burdens in relation to patient safety and governance due to the amount of direct contact with patients with limited or no oversight by peers. For this reason, compliance with the GMC's conditions alone, which do not provide for specific re-training or supervision in the specialty of general practice, would be insufficient to allow a safe return to general practice."*

71. Professor Lewis had reviewed Dr Gilbey's placements since 2009. He commented that the placement at Bronglais General Hospital in Aberystwyth was as a Senior House Officer, namely the position of a junior doctor undergoing training supervised by consultants and registrars. In August 2010, Dr Gilbey took a 1 year locum appointment in a supervised training post at Foundation Year 2 level. The Deanery had no involvement in the post, which Professor Lewis described as a type of post to provide doctors in their second year after graduation from medical school with generic skills rather than specialty training for general practice. Professor

Lewis' opinion was "*This was not sufficient to address Dr Gilbey's performance issues, but the position allowed Dr Gilbey to be employed and to work in a supervised capacity."* The general practice rotation at Lampeter had been terminated early, resulting in Dr Gilbey returning to Bronglais. The Head of the Wales Foundation School, Dr Yapp, had informed the Deanery that it was felt that Dr Gilbey's needs and issues were beyond the remit of the Foundation Programme, that there had been issues with the placements and that if Dr Gilbey had been a trainee in a foundation programme he may not have met the requirements for satisfactory completion.

72. Professor Lewis commented that Dr Gilbey has spent a considerable amount of time on his PDP, which is very good, and he has enrolled on a 25-hour Open University Course 'Developing Yourself for Clinical Leadership', but he has reservations as to how much the PDP can address the deficiencies "…if the practitioner is not in the appropriate clinical practice setting of general practice."

73. In Professor Lewis opinion Dr Gilbey has effectively been out of general practice for over 4 ½ years, which mean that he would in any event have become de-skilled in that field. The Welsh Deanery advises the LHB and LHB performers list panels that all GPs who have not actively practiced for 2 years or more to undergo induction or "returner" training. The first stage of the training is to undergo an entry assessment consisting of a machine marked test of clinical knowledge and problem solving ability, a simulated patient consultation, a written exercise, an interview and a computer exercise to assess IT competency. Where the assessment scores are sufficient, then the returning GP will be recommended for an induction placement at an approved ATP, usually for a period of 6 months full time, or 12 months part time. An ongoing process of assessment and reporting will take place throughout the placement. At the end of the placement, the Deanery recommends that the returner should sit the AKT examination. Professor Lewis stated that the Deanery's returner requirements are informed by the Committee of GP Education Directors' (COGPED) recommendations for GP induction and refresher schemes, although he agreed with Dr Gilbey that there is no statutory requirement for such a scheme.

74. In Professor Lewis's view Dr Gilbey's remediation requirements and conditional status with both the GMC and the Performers List placed him outside the usual remit of a returner placement, but it was agreed that training using the 'returner training' model would be used which would both address his remediation needs as identified by NCAS and the GMC and any loss of skills resulting from his prolonged absence from practice, and was thought to be the most effective and practical way forward. An action plan was drawn up and it was intended that the pre-placement assessment and GMC requirements would inform the training plan. It was agreed that the placement would be part time over a period of 12 months to enable Dr Gilbey to continue to work part time in a hospital post to provide an income and to decrease the burden on the placement practice.

75. On 10 August 2011 Professor Lewis chaired a further meeting between Dr Gilbey, the LHB and the Deanery to discuss the action plan. Professor Lewis recorded that Dr Gilbey expressed some reluctance to go to an ATP. He states "I*t was explained that only the ATPs were experienced in providing training to GPs who had remediation issues identified by NCAS and/or the GMC. The placement would seek to address the NCAS and GMC recommendations, as well as any further issues identified by the planned returner assessment*." Following this meeting both parties worked on a consent order which was entered into in good faith.

76. Professor Lewis explained to the panel that the assessment was carried out with assessors from the Wessex Deanery. Dr Gilbey was interviewed by Dr Gordon Lewis, Associate Dean at the Postgraduate Deanery. Dr Lewis discussed Dr Gilbey's perceived educational needs, his PDP and his concerns about undergoing the placement. One, rather than 2 assessors were used, again to ensure a balanced view.

77. Professor Lewis said that he had been sent the results and had agreed that they should be sent to Pontcae and to Dr Gilbey, but that he had not read them at the time. He said that when Pontcae reviewed the offer of a placement he looked at the scores and was very surprised. He commented that Dr Gilbey's scores were of "*significant concern*" and stated "*Many of the issues surrounding communication, patient and peer relationships, respect and integrity that had been identified by NCAS and the GMC remained. The assessment scores cast doubt on how much could be achieved in the placement as a significant alteration in behaviour, as well as development of skills, would be required*."

78. Professor Lewis explained to the panel that he had personally tried to assist Dr Gilbey. In October 2009 he wrote to all of the ATP's in Wales to see if any practice could offer assistance but none of them were prepared to offer a place. He stressed to us that the Deanery cannot compel an ATP to offer a place. He stated that the withdrawal of the placement at Pontcae in October 2011 was very disappointing and he had realised the consent order of 23 August 2011 was in jeopardy. The Deanery immediately approached all remaining ATPs to see if an alternative placement could be arranged, advising them that there was a former GP seeking a placement who had had a NCAS assessment and was subject to GMC conditions, and providing an anonymised copy of the October 2011 assessment. Professor Lewis explained that none of the other ATPs were prepared to offer a placement on the basis of the poor scores in the assessment, set against the backgrounds of the previous involvement of NCAS and the GMC.

79. Professor Lewis has concluded that Dr Gilbey has undergone 3 separate assessments spread over 4 years, which have all revealed very similar deficiencies in areas which are fundamental to general practice. He states "*In order to have any prospect of addressing those deficiencies and returning to safe practice, Dr Gilbey would need to undergo in-depth*

remedial training in a general practice setting, which in my view can only be provided by an ATP. Despite the efforts of the Deanery over the last 3 years, it has not been possible to secure such a placement for Dr Gilbey and it is extremely unlikely that such a placement would become available in the future. Without successful remediation of the type described, the Deanery could not recommend to any primary care organisation that Dr Gilbey should be allowed to return to independent general practice."

80. Dr Gilbey gave evidence that he was appointed to be a sole GP in Cwmllnfell in April 1988 and over the next 20 years he had expended a great deal of time and energy in developing that surgery and a further surgery in Ystalfera. In the late 1980's he had become interested in computing and had led the way in using computers in his surgeries and to provide prescriptions. He was proud of the advances made and that he was not ever subjected to any external investigation of a patient complaint nor was he sued for negligence. Of the 2006 complaint which started this process Dr Gilbey's statement records "There is clear documentary evidence that ...(the LHB)..planned to obtain evidence against me to support a referral to NCAS prior to any investigation into" …(the nursing home which made the referral).

81. In his statement Dr Gilbey explains that in his view the decision taken to remove him from the Performers list was taken by Drs Harrison and Goodall not because of his clinical conduct but "…part of a reaction to me for raising issues about the awarding and monitoring of local contracts for the provision of medical services." He states that he did not have the opportunity to challenge the LHB assessment by Dr Kirsop, which went outside her remit, and that not only had he not had an opportunity to present his case to the Performance panel but that Dr Goodall had dismissed his appeal without giving reasons.

82. Dr Gilbey states that he was very shocked when he read the draft NCAS assessment and that he had found copious factual errors contained in it. He was advised to respond to the draft, which he did, but he states "Stupidly I questioned the authenticity of the Report. As a result at every meeting, tribunal or investigation I have been labelled (sic) as lacking insight. This continued through the GMC Performance assessment, where the Lead GMC Assessor was highly critical of my reaction to the NCAS report…" He also feels that the GMC assessment used the same material as NCAS to reach it's conclusions whereas if they had looked at his records from OSS there would have been evidence that he had taken the criticisms on board and changed his practices. This was particularly important in respect of record keeping.

83. Dr Gilbey points out that the GMC FTPP did not accept the recommendations of the assessment team that an ATP placement was necessary and comments: "The panel highlighted shortcomings in my record keeping and interpersonal relationships. They were correct. My record keeping cost me my career. Despite my interest in digital record keeping and keeping extremely sophisticated records that were instantly

accessible to the clinician they did not comply with Good Medical Practice nor did they, standing alone, allow me to defend myself against accusations of poor practice. The records were designed to be used with a patient complementing the record, not to defend myself against an inquisition." Further, Dr Gilbey states that "Whilst I appreciated the short comings in my record keeping once pointed out I was also aware that the records at the Old School Surgery did not comply with Good Medical practice or the registration requirements of a training practice in Wales."

84. Dr Gilbey describes the recommendations of Professor Lewis and Dr Harrison as coming from an entrenched position "without evidence and proportionality". He feels that a placement at an ATP is "not without risks" and points out that there is no external quality control to ATP's leading to a situation where in his opinion the OSS were not performing to the standards against which he had been judged, thus leading to unfairness. He comments further that "At the OSS, no doctor had the breadth of experience and responsibility that I had gained in single handed practice." and that following feedback comments made about other doctors and the treatment of patients at OSS he was dismissed. He states "Unfortunately instead of accepting the comments in the manner intended, the OSS partners who also included a sub dean from the Department of General Practice closed ranks."

85. Dr Gilbey criticises the NCAS and GMC assessments as "arbitrary and theoretical" standards of performance where doctors who are found to have performed outside those standards are deemed to have impaired fitness to practise despite the fact that there may be a significant number of doctors practising in a similar way. He said that the FTP did not uphold all of the assessment team findings and recommendations.

86. With respect to his interpersonal skills and empathy Dr Gilbey states that the NCAS assessment was objective and showed these skills to be "outstandingly good" whereas the GMC assessors conducted interviews which were not …"standardised, subjective (sic) and not reproducible" for which they were criticised by the chair of the GMC FTP panel. He continues "Whilst I am not proud of some of the criticisms levelled at me by my employees, there was unusual friction and divided loyalties at the time due to concerns about the future of the Practice. That is not to say that I have not been guilty of poor communication with my colleagues, but I have done everything within reason to address the criticisms leveled (sic) at me".

87. Dr Gilbey said that he saw the placement at Lampeter as an opportunity for him to return to general practice. He states; "Disappointingly things went wrong from the first day. There was no written guidance and no trainee induction pack. There was unease and confusion as to whether I could even sign a prescription for the first few days. The ambiguity concerning my Performer List status appeared to be an issue. I felt feelings of hostility against me that were endorsed when doctors declined to undertake routine assessments and engage with the returner log book."

He stressed to the panel that the role he undertook at Lampeter was of a GP, seeing patients and writing his own referral letters. He was shocked when the placement was terminated without warning and the practice told him he needed an ATP.

88. Dr Gilbey said that he was unaware that the placement at Pontcae was provisional. He criticised the Deanery assessment in 2011 because although he scored 90% in the objective knowledge test (which was "unsurprising") the IT assessment was unsuitable to assess the ability to record a consultation because it was simply a typing test. Further the patient encounter, which he describes as a situational judgment test, was designed as a tool to assess doctors applying to train as GP's and in his view "…has no validity as a tool for measuring training or educational needs." Dr Gilbey also criticised Professor Lewis for failing to answer his letters quickly and for failing to do enough to secure a training placement for him. He praised Ms Dover as having tried to help, and following Dr O'Dwyer's evidence stated that he felt Dr O'Dwyer had tried hard to help him, although he felt that Dr O'Dwyer should have met with him to discuss matters.

Tribunal's conclusions with reasons

89. We have carefully considered both the written and oral evidence before us and the submissions made by Dr Gilbey and on behalf of the Respondent. We have applied the law as set out above and have considered each of the issues in turn and globally. We wish to make it clear at the outset that we did not treat any of the witnesses as an "expert" in the sense of an independent expert, although we recognised that each has considerable experience in their own fields.

90. We are not satisfied on the balance of probabilities that the contingent removal should be revoked or that the conditions should be varied or amended as suggested by Dr Gilbey and so the appeal is dismissed on that basis. The LHB have not yet removed Dr Gilbey from the list under Reg 15(6)(b) but we are aware that our decision will almost certainly lead to Dr Gilbey being removed from the Performers List by the Respondent. We outline the reasons for our decision below.

<u>Should the contingent removal embodied in a consent order on August 26 2011 be revoked? In the event that the current conditions are not revoked, should Dr Gilbey be removed from the Performers List by the Tribunal as the conditions are unlikely to be fulfilled?</u>

91. It was clear to us on the balance of the evidence that it would not be safe for Dr Gilbey to return to practice as a GP without extensive remediation as provided for in the terms of the consent order application. Those conditions have in a large extent failed. We find that the failure of the conditions is down to Dr Gilbey. The condition at 6.1 provides that Dr

Gilbey will undergo “such pre placement assessments as may be deemed appropriate to his learning needs by the Welsh Deanery”. That assessment took place on 13 October 2012 and although at a fairly basic level – entry to training as a GP- Dr Gilbey failed the test with remarkably low scores for communication and empathy. We accept fully that the score of 90% on clinical knowledge is very good, but that has never been an area criticised by assessors. What is very significant is that Dr Gilbey was on his own evidence using all the communication and empathy demonstrating skills he has learnt and yet in the test using an actress he scored very badly.

92. We are satisfied that the Deanery were being fair when using this test. Not one but two outside assessors were used and the interviews were conducted by an out of area doctor. The test was at a basic level which should have given Dr Gilbey an opportunity to shine. We are astonished that at this crucial test to help assess his training needs for an identified ATP Dr Gilbey chose to voice concerns about whether such a placement was needed. He was fully aware from the history of the training provider search that it had been very difficult to identify an appropriate placement. He was fully aware from the GMC and NCAS assessments what his identified deficiencies were and yet Dr Gordon Lewis records “*Dr Gilbey indicated some uncertainty about what educational value will be gained from an FTP placement. He is keen to be a valued and respected member of a team but feels he will be treated as a surplus member of staff in the practice*.” Dr Lewis felt the need to emphasise to Dr Gilbey the importance of Dr Gilbey entering into a placement with an open mind and to work to earn the respect of his colleagues. He wasn’t the first person to do so. The transcript of the meeting to try to resolve the issues gives further evidence of the PCT position being clearly and unambiguously explained.

93. We have no doubt that Dr Gilbey’s remarks, coupled with the very low scores for demonstrating empathy, communication and problem solving (recorded in paragraph 50 above) were sufficient to tip the balance at Pontcae surgery from a cautious offer of a placement to a doctor who had challenging requirements to a decision to withdraw the offer. It is very sad that Dr Gilbey still cannot see that the person responsible for that failure is himself, and that there really is nobody else to blame. We accept Dr O’Dwyer’s evidence that in his experience the test is an accurate predictor of performance at an ATP because he has had recent experience of four placements where the test has been taken by a person subsequently attending Pontcae and has been able to look at their progress in the light of their results, and his evidence on this was well reasoned and properly analysed.

94. We concluded that Dr Gerry O’Dwyer’s evidence was thoughtful and balanced and demonstrated him to be a man of integrity. We are satisfied that he did his very best to help Dr Gilbey, but faced with the scores in the October test and the arrogant remarks to Dr Harris, we are not at all surprised that the Pontcae partners meeting took the decision to withdraw

the offer. We find that their action was appropriate, proportionate and not affected by outside influence. We are not satisfied that the withdrawal of the place was due to pressure from the LHB or the Deanery. Dr O'Dwyer was clear that there was no attempt at outside influence and we were satisfied that his professionalism would have inevitably meant that he would have resisted it even if it had taken place. Our view is strengthened by the fact that when the test results were sent by the Deanery to Pontcae the covering letter still clearly envisaged the placement going ahead. Dr Gilbey's assertion that there must have been such pressure is in our view a further manifestation of his always seeking an external explanation. The reality is that he failed the core parts of the test at a level which would prevent a 2 year experienced doctor being selected for GP training and that he continued to remain of the arrogant view that an ATP was of limited educational value to him.

95. Sadly this is not the first time Dr Gilbey has chosen not to look at his poor assessment record as down to his own performance. He has questioned the NCAS report assessment process, the GMC assessment and the Deanery assessment, the assessors and their methodologies because he cannot accept that he has really significant communication difficulties and lack of patient empathy. The consistency of this attitude and the time over which nothing has changed reinforces our view that Dr Gilbey's training needs are such that there would be a significant risk to his patients if the contingent removal were to be revoked. A GP with this record who believes himself to be safe is without doubt in our view manifestly unsafe.

96. We are not convinced by the LHB submissions that we have the jurisdiction to remove Dr Gilbey from the list under Regulation 15(6). This application is not an appeal from an LHB decision where the Tribunal has wide powers but a stand alone application to vary the conditions. In our view the Tribunal has wider powers in the former situation because the various procedures for removal have been complied with and the appellant has had notice of the decision. It was open to the LHB to undertake that course but it has not yet done so.

<u>Should the current conditions as agreed in the 26 August 2011 consent order be revoked?</u>

97. We are satisfied that the only appropriate retraining conditions were those identified last year, including the placement at Pontcae, an ATP. We are not satisfied by Dr Gilbey's submission that it is safe for him to return to GP practice under the conditions imposed by the GMC, that his remediation needs have been addressed and that there is no need for any further requirements. We have decided that even as a returner with no remediation needs Dr Gibley would require an ATP placement on the basis of the evidence of Dr Harrison and Professor Harris. We accept that although not a statutory requirement there are substantial reasons why such training is needed in order to ensure patient safety, and that is at the heart of the PCT role.

98. As things stand Dr Gilbey has not had a successful GP placement at either OSS or Lampeter. We have listened to Dr Gilbey's criticisms of the OSS and how in his view the doctors there had similar faults to his own. It would appear that the placement started well, but that Dr Gilbey then began to question what others were doing rather than concentrating on his own work and the reasons he was there. Dr Gilbey's arrogance appears to have surfaced to such an extent that the placement failed, and we do not find that there is any justification to Dr Gilbey's assertion that this placement has assisted with remedying his identified practice deficiencies. His insistence that he was speaking up for patients is not in our view the motivation for his actions. On the contrary, his criticism of the ATP and the doctors in it was clearly founded by his belief that he was more experienced and more talented than they were. This was particularly highlighted by his view expressed to us in evidence, including: "I don't need an ATP or even a TP where I'm not an employee"; "I was proud of my practice- I may have been misguided to tell NCAS it was one of the best practices in the land". Similarly, although his statement records that he has not questioned the opinions of the NCAS assessors when the findings of the report were put to him by Mr Hyam with the simple question "Do you accept those findings?" the answer was "No, I accept record keeping, infection control and possibly patient examination technique" which falls far short of the totality of the deficiency they, and others subsequently, have identified.

99. Sadly, the experience at Lampeter appears to have failed for not dissimilar reasons to those for the failure at OSS. We do not accept Dr Gilbey's assertion that the placement failed as a result of pressure from the Deanery and we accept Mrs Dover's evidence that the Deanery only became involved when contacted by the surgery itself. This was a placement arranged and entered by Dr Gilbey and was not part of a retraining package organised by the Deanery. The Deanery confirmed to Lampeter that Dr Gilbey could practice there under the Performers List conditions. We are satisfied that once again the placement failed due to Dr Gilbey's actions and how he was viewed by his colleagues rather than any external features or pressure. We are concerned that following a Deanery Annual Review of Foundation Progress Dr Tom Yapp wrote in July 2011 that the panel had felt that Dr Gilbey's performance in this Lampeter F2 post demonstrated that "…*his needs and issues went beyond the Foundation Programme".* This, coupled with the significantly low levels achieved in crucial aspects of the October 2011 assessment demonstrate the extent of the problem, and we are satisfied that nothing short of an ATP placement with extensive external support could ensure patient safety if Dr Gilbey were to be returning to GP practice.

100. The LHB position throughout was that no condition less than the requirement of placement at an ATP would suffice. Dr Gilbey did not put forward any alternative conditions until his closing submissions when he suggested that we could require him to work in a salaried position or in an out of hours placement or drug rehabilitation position. We do not think that such conditions would be anywhere near robust enough to address patient

safety because we have concluded that Dr Gilbey requires close support and supervision by experienced trainers with a high level of expertise such as those at Pontcae.

101. We reject Dr Gilbey's continued assertion that the provision in ATP's is not appropriate to him. Professor Lewis and Dr O'Dwyer explained how the ATP's were set up and the work they undertake. Dr O'Dwyer epitomised the professionalism and commitment which trainers at ATPs demonstrate. When asked "*What's in it for you*?" Dr O'Dwyer explained that he relishes the challenge to help a doctor back on their feet no matter what the difficulty. He dedicates a good part of his time to training and he and his colleagues demonstrate a selfless commitment to assisting others for very little financial reward or sadly in this case, recognition by Dr Gilbey until the eleventh hour.

Was the Deanery assessment is a valid assessment of Dr Gilbey's training needs or was it flawed?

102. We have concluded that the assessment performed was at a low level but that it clearly demonstrated continuing shortcomings and was a reasonably accurate predictor of training needs as stated by Dr O'Dwyer. Dr Gilbey said "*It didn't give me enough scope to show my abilities*". In our view the test gave him the appropriate opportunity to do just that- he should have been ale to score 90% across the board.

103. There was no evidence that Mary Beech had "entertained" the assessors in any way which might affect their assessment nor were we satisfied that Dr Gilbey had not been prepared for what would happen. It is clear from the transcript of the meeting organised to discuss the training package that Dr Gilbey had significant issues with being tested. It is also clear that he was given precise details of what the test would involve, backed up in an email. Dr Gilbey complained to us that there should have been a surgery simulation rather than a single role play of speaking to the relative of a patient with special educational needs who was being treated by a colleague. Dr Gilbey told us that he thought the test was about the new complaints procedure and he had approached the consultation on that basis, using all his communication and empathy skills to approach the encounter. The actress playing the role raised concerns about Dr Gilbey's approach. Having had extensive opportunity to assess Dr Gilbey's communication style the panel have concluded that his laboured, self centred and ponderous style would have prevailed, and once he had decided "what the test was about" he would have taken the course of outlining the new complaints procedure rather that looking at the issues of patient confidentiality, the right to a second opinion, and other professional issues which this fairly standard low level test is designed to test.

Whether the tribunal is satisfied on the balance of probabilities that Dr Gilbey has addressed the deficiencies identified by NCAS, the FTP and the Deanery assessment and shown insight into his training needs?

104. The panel have carefully considered Dr Gilbey's case that the NCAS assessment is flawed by factual errors, that the GMC assessment recommendations were not followed by the GMC FTP panel and that the Deanery assessment was an inappropriate test, unfairly administered. Dr Gilbey has maintained throughout that he accepted the opinions expressed by the NCAS assessors and that he has addressed the issues of record keeping, communication and demonstrating empathy evidenced by the excellent current references provided to the panel, but that the factual errors in the NCAS assessment should have been addressed.

105. In our assessment Dr Gilbey has paid lip service to the opinions of the NCAS assessors and has never really demonstrated an ongoing acceptance of the deficiencies they identified. In respect of record keeping it is striking that he still makes statements like:"*The records were designed to be used with a patient complementing the record, not to defend myself against an inquisition.*" and "*Whilst I appreciated the short comings in my record keeping once pointed out I was also aware that the records at the Old School Surgery did not comply with Good Medical practice or the registration requirements of a training practice in Wales*."

106. Equally, Dr Gilbey did not at any time acknowledge that the standard of his performance at the October 2011 test showed ongoing deficiencies in patient communication and empathy. He said "*It didn't give me enough scope to show my abilities. It was about identifying needs that I want to address – if they are there. In England they take into account a whole surgery, Professor Lewis used a process to select candidates, not to assess my needs. Further, the predictions are invalid. There is room for error in any situational judgment so it's not a valid test. We weren't given a reference as to where it was validated. You can't use it to say "That person has problems with problem solving and empathy. It was a bare room and it had horrid furniture.*" We have borne in mind the fact that Dr Gilbey scored well in patient satisfaction and peer assessments in the NCAS assessment, and that he has provided references which show that in his recent placements he has been praised for these skills, and that he is entitled to draw this apparent conflict to our attention. We have also borne in mind the fact that the GMC did not feel it necessary to follow the recommendations of the assessment panel and that Dr Gilbey scored well in the Severn assessment. In terms of insight however we assess that Dr Gilbey has fundamentally not accepted that there was or could be anything amiss and is clear that if there was then it has been remedied to the extent of him only requiring, at the most, remote supervision.

107. We have concluded that there is a core consistency between the NCAS assessment, the GMC assessment and the Deanery assessment of basic communication deficiencies and a lack of empathy and sensitivity. The latter assessment took place at a time when Dr Gilbey was at Lampeter in a quasi GP situation, so at a time when he had the opportunity to put his skills into practice. Further, the Severn assessment, which Dr Gilbey relies on as an independent example of a successful

assessment was paper based and did not involve a “live” assessment of how Dr Gilbey acts with others so we think it is in our view it is less useful because it doesn’t assess body language and active listening.

What are the current risks to the public of Dr Gilbey returning to be a GP without further training?

108. Dr Gilbey suggests that there are no risks to the public since the GMC conditions he is subject to, and which involve remote supervision, were imposed to address any risks. We have considered this submission carefully, because we respect the GMC as a professional body looking at fitness to practice issues. We have considered the evidence of Dr Harrison and Professor Harris that the issues of fitness to practice are very different to the issues faced by an LHB charged with ensuring patient safety.

109. We are satisfied that the role of a GP and the LHB duty to maintain a performers List to maintain public safety are singular and very important. GP’s often work in isolation and without the immediately available professional support of colleagues. They are under time pressures and often have to deal with multiple medical and social issues. Their role is no more or less important than the role of a hospital doctor but it is a very different role for which communication skills and empathy are crucial. Dr Gilbey points out that he did not have any externally investigated complaints or law suits against him when he was a GP but in our view that misses the point. In every objective assessment conducted since the complaints raised by the nursing home serious shortcomings have been highlighted. Dr Gilbey has managed to improve his patient communication skills in a junior role in the highly supported environment at the hospitals in which he has worked during recent times, but not as a GP. We do not accept that the placements at OSS and Lampeter demonstrate sufficient exposure to life as a GP because both were short and in circumstances removed from normal GP practice. Acceptable GP experience and training could have occurred in a highly supportive ATP with built in safeguards for patients but cannot in our view take place safely with remote supervision.

110. We have concluded that the evidence of Professor Lewis and Dr Harrison of the risks to the public of a GP who lacks empathy and communication skills is compelling. Dr Harrison and Professor Lewis concurred in the view that there would be significant risks to the public from a GP who has remediation needs and has been away from practice to return to work as a GP without at least 6 months in an ATP and that those risks would not be met by the more remote supervision of Dr Gilbey required by the GMC. We agree, because the consequences for just one patient needing empathetic listening without prejudging of not having their problems diagnosed and acted upon could have devastating consequences. The fact that Dr Gilbey has never been sued does not fill us with confidence. We were particularly alarmed at his evidence that *“I think it’s pompous to say GP’s are more patient centred. It doesn’t matter where it is*” which in our view demonstrated a fundamental lack of understanding of the role of a GP and increases the risk to patients.

Whether the LHB and the Deanery have either individually or together acted against Dr Gilbey's interests

111. Dr Gilbey feels that whilst Hillary Dover and Dr O'Dwyer had attempted to assist him, he believes that Professor Lewis and Dr Harrison amongst others had not done enough to assist him return to practice. We were not satisfied that either of these witnesses had any agenda against Dr Gilbey. Dr Harrison gave measured and balanced evidence which was directed to the issues and showed no signs of exaggeration or attempts to make unfair criticisms of Dr Gilbey. We were also satisfied that Professor Lewis had actually done more for Dr Gilbey than his role strictly entails and that he had done everything in his power to secure and maintain the placement at Pontcae and to find an alternative when that placement was withdrawn... We have concluded that the Deanery has spent a great deal of effort, time and money to support Dr Gilbey, and there is no evidence that there have been any 'dirty tricks' or attempts to undermine him. We were not satisfied that Professor Harris lied to us when he said that he had not read the assessment report until the Pontcae surgery reviewed their offer. Had he read it at the time of receipt in any detail we are sure he would not have been optimistic for its use in the training at Pontcae because he would have no doubt anticipated that they would be likely to withdraw their offer.

Whether Dr Gilbey has been unfairly prejudiced by the fact that he has had to criticise other Doctors and the assessments in order to defend himself against the allegations made against him?

112. The panel understand how Dr Gilbey may feel that he has been put in a Catch 22 situation and fears that we will criticise him for lack of insight because he has considerable reservations about the assessment methods used to identify his deficiencies, and about standards in ATP's and we have borne this in mind. Having weighed the evidence however the overwhelming balance of Dr Gilbey's evidence has been of criticism of the processes and people involved in the various assessments without any serious self reflection. We find that Dr Gilbey has taken an entirely disproportionate stance resulting in almost his entire focus being on the inadequacies of others rather than his own deficiencies. This stance continued even into his closing submissions. We acknowledge that he currently has good references but we have concluded that Dr Gilbey is able to function far better in a supported hospital environment as part of a team. In a GP environment where others are able to observe him or when independently assessed the experience is very different and the evidence clearly demonstrates that that is where he fails.

Overall conclusions.

113. Having considered the findings on each issue and the global evidence we are not satisfied on the balance of probabilities that the contingent

removal should be revoked or that the conditions should be varied or amended as submitted by Dr Gilbey and therefore the appeal is dismissed

ORDER

Appeal dismissed

Judge Nancy Hillier
Lead Judge Care Standards and Primary Health Lists.
13 June 2012.