The First-tier Tribunal

(Health, Education and Social Care Chamber)

Primary Health Lists

Appeal Number: PHL/15440/15441

Between

Dr Kamlesh Ojha

(GMC registration number 2322722)

Appellant

and

Aneurin Bevan Local Health Board

Respondent

The panel

Mr Brayne, Judge

Dr Sharma, medical member

Mrs Last, lay member

Representation

Counsel for the appellant: Mr Bull, QC

Counsel for the respondent: Mr Hyam

DETERMINATION AND REASONS

The Appeal

1. By notice dated 8 November 2011 Dr Ojha appeals against the decision of the Aneurin Bevan Local Health Board (the LHB) dated 7 October 2011, and communicated to Dr Ojha in a letter to Dr Ojha dated 13 October 2011, to remove his name from its performers list.
2. The Respondent's decision was made on the grounds of efficiency and of suitability, under Regulations 10(3) and (4) (a) and (c) of the National Health

Service (Performers' List) (Wales) (Regulations 2004, as amended (referred to below as the 2004 Regulations).

The legal framework for removal

3. Regulation 10(3) of the 2004 Regulations provides as follows:

> *The Primary Care Trust may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.*

4. Regulation 10(4)(a) sets out the test for removal on grounds of efficiency:

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

5. Regulation 10(4)(c) provides for removal on grounds of unsuitability:

> *[the] performer is unsuitable to be included in the performers list ("an unsuitability case").*

6. Regulation 12 states that the LHB, in an efficiency case, may,

> *instead of deciding to remove a performer from its performers list, decide to remove the performer contingently.*

Background to the Respondent's decision

7. The respondent relies in the response to the appeal on a written statement of case prepared by Dr John Holland for the Reference Review Panel which made the decision under appeal. The following chronology is based on that statement of case. We have seen the relevant documents, and though Dr Ojha contests some of the opinions and decisions set out in the chronology, he does not dispute the chronology itself.

8. Dr Ojha was, at the time of the decision, an independent practitioner in a two partner practice within the Caerphilly Locality, serving 2,980 patients.

9. He was reprimanded by the General Medical Council (GMC) in 2003, and recommended to undertake further training in cardiovascular disease, diabetes, complaints handling and communication skills.

10. The practice was formally assessed in May 2005 by the Primary Care Medical Adviser of the then National Public Health Service for Wales, who found deficiencies in Dr Ojha's performance in the areas of record keeping, chronic disease management, and the selection of therapeutic agents. A local action plan was drawn up, and a Reference Panel contingently removed Dr Ojha to mandate his co-operation with this plan.

11. In March 2006 a Reference Panel suspended Dr Ojha from the Performers List and requested an assessment from the National Clinical Assessment Service (NCAS).

12. The NCAS report of November 2006 found deficiencies in Dr Ojha's performance in categories of record keeping; chronic disease management; assessment of patients' conditions; prescribing; examination techniques; communication with patients; complaints management; and practice

leadership and management. He was recommended for formal supervised retraining.

13. A retraining package was agreed between the then Caerphilly teaching Local Health Board, the Deanery and Dr Ojha.

14. In July 2007 the GMC undertook a performance assessment of Dr Ojha and found six areas which were unacceptable, and one area of concern. The unacceptable areas were assessment; treatment; record keeping; communication; respect; and relationships and law. The GMC referred to the above retraining package agreed between the then Local Health Board and Dr Ojha, and mandated a follow up performance assessment after Dr Ojha's return to practice. This assessment was conducted in March 2011 (see below).

15. The training package took place from January to December 2008. Dr Ojha reached the minimum requirements after this training, but failed the MRCGP applied knowledge test.

16. A Reference Panel then altered the conditions of the contingent removal to allow Dr Ojha to return to his own practice, subject to the conditions that he have direct salaried GP support within the practice; meet regularly with the Medical Director; provide reflective statements; and accept practice management support. The most recent conditions in force before his suspension from practice were those set out by the respondent in November 2010: monthly meetings with the medical director; monthly meetings with LHB management support staff; weekly practice team meetings; to undergo an occupational health review prior to returning to full time work; and to accept salaried GP support for a further four months.

17. A GMC performance assessment took place in March 2011. Dr Ojha's professional practice was found to be below that expected of a general practitioner and he was not considered to be suitable to perform as a GP principal.

18. The respondent then, in the decision now appealed, removed Dr Ojha from its performers list.

The Respondent's case

19. Dr Holland's statement of case, which the respondent relies on in these proceedings, gives the following reasons why Dr Ojha is considered unsuitable for inclusion on the performers list.

20. Firstly, he is said to lack the essential knowledge, evidenced by his inability to pass knowledge tests in both 2009 and 2011. Half his judgments regarding treatments in his GMC simulated surgery were judged unacceptable.

21. Secondly he is said to lack the essential skills of a GP, evidenced by his failure to pass the GMC Performance Assessment OSCE (Observed Structured Clinical Examination). His performance in the GMC simulated surgery was found to be below the performance of all the comparator GPs, and he failed to perform adequate basic life support in an OSCE station.

22. Thirdly he is said to lack the essential attributes of a GP in maintaining good relationships with patients and colleagues, as evinced by the GMC

performance assessment report in terms of unacceptable performance in the areas of relationships with patients and of working with colleagues, and also by evidence of his care of patients in a named residential home.

23. Fourthly he is said to lack the essential attributes of a GP in maintaining adequate medical records, as evidenced by a finding of cause for concern in the BMD performance assessment, and by evidence of an alteration by Dr Ojha of medical records.

24. The respondent relies on the following reasons for removal on grounds of efficiency.

25. Firstly, Dr Ojha's management of cases of cardiovascular disease is said to be significantly below that expected of a GP, as evidenced by the GMC reprimand and recommendations of 2003 and a case referred by the GMC to the respondent for further interventions.

26. Secondly, Dr Ojha is said to repeatedly fail to take adequate history or to perform adequate examination of patients, as evidenced in appendices to Dr Holland's reports and in the GMC performance assessment findings of cause for concern.

27. Thirdly, Dr Ojha is said to repeatedly select incorrect treatments for patients, as evidenced by the GMC performance assessments which found cause for concern in this area.

28. Fourthly, it is said that Dr Ojha fails to adequately maintain good medical practice, as evidenced by the cause for concern found by the GMC performance assessment.

29. The respondent then refers to the support provided by the respondent to Dr Ojha to improve his knowledge and skills, by way of the action plan in 2005, formal GP retraining in 2008, and ongoing support from an experienced salaried GP until April 2011. Despite this support and retraining, the respondent submits that there has been no sustained improvement in the standard of care offered by Dr Ojha to his patients. The respondent also refers to a failure to adhere to the conditions imposed by a previous reference panel.

30. In response to the Tribunal's directions of 5 December 2011 the respondent helpfully set out a schedule of findings sought and issues to be determined. These are listed in submissions dated 18 January 2012 and found at section b 1-3 of the hearing bundle.

31. The respondent at paragraph 18 of these submissions summarises the financial and time costs of support for Dr Ojha. Between October 2005 and March 2006 an estimated 659.5 hours were provided to the practice. Between March 2006 and September 2007 17 sessions a week, together with 49 Healthcare Assistant sessions and 11 nursing sessions were provided. Between September 2007 and April 2009 779 sessions were provided to Dr Ojha's practice. Between April 2009 and November 2010 a further 328 sessions as well as 44 Healthcare Assistant sessions and 53 nurse sessions. Between November 2010 and April 2011 42 sessions of GP support were provided.

32. The above submission invites the Tribunal, if it finds removal to be justified on efficiency but not on unsuitability grounds, to consider whether there are workable and practicable conditions as an alternative to removal on efficiency grounds, to consider that removal is justified on grounds of efficiency.

33. Further, if the Tribunal confirms Dr Ojha's removal from the performers list, the respondent invites the Tribunal to consider a national disqualification.

The appellant's case

34. Dr Ojha's reasons for appeal are summarised as follows. The surgery had operated in rundown premises since July 2002 for some four years. When this was pointed out to the LHB "we were subjected to relentless persecution, harassment and victimisation."

35. The LHB had acted as "judge and jury" in its decision to suspend Dr Ojha, giving no option of appealing that decision. At that time he had been undergoing radiotherapy treatment, but the hearing had continued until 11 pm.

36. He had been referred to NCAS and taken on board the recommendations from NCAS, but the training programme had then been blocked. The recommendations of NCAS and the GMC had been ignored.

37. He had accepted the GMC retraining recommendations in July 2007 and had been mentored and supervised by Dr O'Dwyer, and had had monthly meetings with the LHB's medical director Dr Southan. At a review probity panel meeting in November 2010 Dr Southan had stated that he had no further concerns about Dr Ojha's practice.

38. He had undergone the required GMC re-assessment in April 2011 and this had recommended that he was fit to practise on a limited basis under supervision and that he should undertake a further personal development plan. He had contacted Dr Lewis, head of the local deanery, and obtained written agreement from his advanced GP training supervisor Dr O'Dwyer. At the date of the appeal he had received an invitation to start formulating the PDP at the Deanery.

39. The recommendation to the probity panel in October 2011 had made only one recommendation, and had ignored the GMC recommendations.

40. He also stated that the respondent was wrong to say he did not have insight into the duty of care to his patients and did not have awareness of his accountability and responsibility as a GP. This was not supported in the GMC findings or in the medication report included in the GMC report, or in relation to the alteration of the medical records.

41. The respondent was wrong to rely on the cardiovascular case management issue. The GMC panel had only had access to one set of computer records, whereas Dr Ojha had access to the full patient history, medication review, and knowledge of his compliance and symptoms. He had pointed out to the panel that he had only once seen this patient, the patient had never suffered from CVD, and the NSAID medication had been initiated by secondary care for a number of years with no significant side effects.

42. It was not accurate to state that he had breached the conditions of practice, in working more than eight sessions and working as a practice manager. Dr

Southan had, in November 2010, recommended a return to full time practice with immediate effect. Additionally an occupational health assessment had resulted in no concerns with his return to full time practice. Dr Ojha's responsibility as practice manager had been taken over by a newly appointed practice manager in April 2011.

Our powers on appeal

43. A decision to remove a performer's name from the list maintained by any PCT on any of the grounds provided under the NHS Regulations is subject to appeal to the First-tier Tribunal.

44. The powers of this panel are to be found in Regulation 15 of the 2004 Regulations, which provides as follows:

> (1) *A performer may appeal (by way of redetermination) to the First-tier Tribunal against a decision of a Primary Care Trust as mentioned on paragraph (2)*
>
> *(2) The Local Health Board decisions in question are decisions-*
>
> *.....*
>
> *(d) to remove the performer under regulations 8(2), 10(3).....*
>
> *(3) On appeal the First-tier Tribunal may make any decision which the Local Health Board could have made.*

45. Regulation 18A (2) allows the First-tier Tribunal, if it decides to remove an appellant from a performers list, to impose a national disqualification.

The hearing

46. The hearing lasted from the beginning of the afternoon of 23 April to mid-afternoon 27 April 2012. Previous directions had been agreed to allow witness statements to stand as evidence in chief, and that two respondent witnesses were unavailable to attend. (Mr Bull raised the absence of evidence of Dr Naranayan being out of the country at the hearing itself, but as he had not raised this in the directions hearing, this implied objection to reading her statement was refused.) Mr Bull told the panel that Dr Ojha's witness, Dr Southan, was not willing to attend without a summons. He did not seek an adjournment for the purpose, and in any event the matter had been explicitly addressed in previous directions which explained to Dr Ojha what he would have to do if he wanted the Tribunal to issue a summons.

47. Following cross examination of each oral witness, the panel asked any questions it thought relevant, to enable counsel in re-examination to address all remaining issues. Where the panel's questions potentially raised further matters which might be open to further cross examination, counsel was offered an opportunity.

The written evidence

48. Statements were provided for eleven witnesses relied on by the respondent. For one of these witnesses, Dr Narayanan, two statements were provided. Dr Ojha provided a witness statement setting out his own evidence, together with statements for the three witnesses he relied on.

49. Section e of the hearing bundle contained the respondent's statement of case to the panel whose decision is now under appeal (referred to above at paragraph 7) and the 17 appendices to that statement.

50. Section f, correspondence between the parties, was not referred to in the hearing or submissions and is not considered further.

51. Section g contained relevant statutes and guidance, and also a GMC assessment of the appellant carried out in 2007.

52. In the course of the hearing we had submitted to us two public documents from the GMC, one containing the definition of a relevant term and the other describing its requirement for undertakings. Dr Ojha referred in his evidence to a personal development plan and the input in formulating this he had received from the Deanery. Although a copy of the plan was in the documents already submitted, handwritten notes relating to this plan which Dr Ojha said were made by the Sub-Dean, Dr Price, were also made available.

53. Dr Ojha referred in his evidence to the contents of his diary for 201. He brought the original for our perusal, as well as his 2011 diary.

54. The contents of all witness statements, exhibits and documents are referred to, where relevant to our decision, below, but all were carefully considered.

The oral evidence

55. Directions previously agreed enabled the witness statements of the parties to be taken as evidence in chief, and apart from some preliminary matters, the witness was then tendered for cross examination on that statement. In the case of Dr Ojha, Mr Bull examined him on the respondent's earlier evidence before he was tendered for cross examination. After cross examination the panel asked questions of all but one witness. The witness was then re-examined by either Mr Hyam or Mr Bull. We are grateful to counsel on both sides for the help and courtesy shown in enabling the large number of witnesses to be dealt with efficiently and within the overall timescale laid down in earlier directions. The witness evidence was heard over four days, 23 to 26 April 2012.

56. The oral evidence was noted in summary form by Judge Brayne, and is referred to where relevant in the decision below.

Determination with reasons

57. We have set out above a summary of the issues raised in the notice of appeal and the response. Mr Hyam in his closing submissions grouped the allegations made by the respondent under ten headings. He also identified a further discrete heading setting out an allegation made by Dr Ojha. We consider these provide an appropriate framework for a determination of the factual issues, though we have not taken them in the precise order submitted by Mr Hyam.

<u>Dr Ojha's allegation that the respondent has acted in bad faith.</u>

58. This allegation was raised in Dr Ojha's grounds of appeal. At the beginning of the hearing the Judge asked through counsel if the bad faith, which included allegations of racial bias, were to be pursued, and Mr Bull confirmed that this

remained the case. In the event no allegations relating to race or ethnicity were put in cross examination, nor relied on in closing submissions. In response to questions put by the medical member to Dr Ojha, reference was made to the ethnic make-up of single handed practices in the LHB area. Mr Bull then referred to this matter in his closing submissions, but only to the extent of mentioning that Dr Ojha had raised it.

59. We do not consider, in the absence of cross examination of the respondent or any other evidence concerning the ethnic make-up of different practices in the respondent's area can be the basis of a finding.
60. However the bias issue was clearly put in evidence and requires consideration. In discussing this issue, and indeed later, we will refer to the respondent and its predecessors as the Local Health Board, or LHB. We are aware that there have been a number of reorganisations during the relevant period, but Dr Ojha implicitly referred to continuity of approach between the present LHB and those predecessors, and this was not challenged.
61. Dr Ojha's evidence is that relationships with the LHB first began to deteriorate as a result of his complaints that promises to provide new premises, to replace the portacabins in which he and Dr S Ojha started the practice, were not initially carried out. The LHB had been unhappy that questions were raised in parliament. It was put to Dr Holland, who is now the medical director and had formulated the advice to the panel which removed Dr Ojha from the LHB performers list, that he was personally biased. Dr Holland denied this, though he accepted that relationships with Dr Ojha had deteriorated, possibly as a result of him asking Dr Ojha when, after completion of his training with Dr O'Dwyer in 2010, he would be returning to work full time. He said this was not with the intention of putting pressure on Dr Ojha, but because the LHB was providing support for the surgery and needed to know what rotas needed to be organised. Dr Ojha submitted that things were going well in terms of his return to work before Dr Holland took on the medical director role, and that Rachel Way, a LHB member of staff who worked closely with Dr Ojha's practice, warned Dr Ojha that Dr Holland's appointment to this role meant he could expect trouble. Ms Way denied saying this.
62. One of the respondent's witnesses was Dr Graham, who is the Medical Secretary to the Local Medical Committee, and in that role has given Dr Ojha support on a number of occasions. He is not employed by, or answerable to, the LHB in this role. Although not mentioned in any previous statement or correspondence, and not put to Dr Graham in cross examination, Dr Ojha told the Tribunal that Dr Graham had "had his elbow twisted" by the LHB to give the evidence he did, and had told Dr Ojha in the course of several telephone calls that he could not give the evidence to the Tribunal which he would have wished to. The context for this allegation is that Dr Graham made some comments in his evidence as to Dr Ojha's lack of insight, but otherwise described him in a relatively positive light in his evidence.

63. Dr Ojha considered much of the evidence against him had been fabricated, and that the LHB had put pressure on people to collect evidence against him. He was also critical of witnesses who raised their concerns directly with the LHB rather than raising them first with him.
64. Dr Ojha also criticised Ms Way in particular, and the LHB in general, for their failure to support his Employment Tribunal case in which he was alleged to have unfairly dismissed an employee. He said that Rachel Way had explicitly advised him to get rid of this employee, and then failed to provide the requested witness statements for the Employment Tribunal, so he in the end had to settle the case. He said this was a commercial decision, in other words he settled it to save costs, rather than on its merits.
65. He criticised Ms Way for failing to bring concerns directly to his attention before reporting them to the LHB, or in third party interview to the GMC.
66. Dr Ojha said that the LHB had deliberately set out to get more evidence against him after the GMC findings in 2011, and Mr Bull referred to the letters of complaint raised by the manager and patients at a local residential home, all received on similar stationery and in similar style on the same day. The manager of the home agreed that she had been asked to submit evidence of these complaints.
67. Dr Graham told us of the hearing before the LHB in 2008, when Dr Ojha was unwell as a result of receiving cancer treatment, of a hearing that had lasted until 11 pm. Dr Graham stated that in his opinion this was not appropriate, and that he would have said this to the panel.
68. Dr Ojha took issue with a number of complaints made to the LHB or the GMC which he said should have been first discussed with himself, and implied that this was evidence of the LHB's unfair approach. If we leave aside, for now, whether we accept that none of the witnesses were truthful in saying they did raise concerns with him (for example the practice nurse Lesley Keyes, or LHB employee Rachel Way) it still remains for us to consider whether making concerns known to the LHB or GMC is, or is not, an improper way to proceed.
69. It should go without saying that if the GMC invites a person for a third party interview, that person should honestly answer the questions put. The fact of having done so, in itself, cannot be a legitimate criticism or ground for believing that the person is in some way predisposed to undermine Dr Ojha. Dr Holland gave unchallenged evidence that about 50% of complaints concerning GPs are sent directly to the LHB, without them being raised first with the practice. In any event a person in the position of Rachel Way, whose role was to assist the practice because of the previous concerns, cannot be expected not to report to the public body which has arranged for that support to be provided. We consider that the implicit suggestion that she should not have passed on her concerns to the LHB are misguided. It would be a matter of concern if she had not done so. That duty is not affected by the question of whether she should first have raised matters with Dr Ojha, which we consider as a separate issue.

70. Dr Ojha accepted, in cross examination, that a nurse such as Ms Keyes has a professional duty to report concerns, so the fact of her doing so cannot be evidence showing she was somehow doing so out of bad faith.
71. There is some merit in aspects of Dr Ojha's complaints. We would, in particular, consider a hearing which had commenced at 10 am, as we were told it had, and finishing at 11 pm was wholly inappropriate and oppressive to all concerned. We understand that shortly after this Dr Ojha commenced proceedings, together with his wife Dr S Ojha, for racial discrimination, which were settled in their favour. We were not provided with further details. On its own, we do not consider this incident shows targeting of Dr Ojha. Taken together with other evidence, it could be relevant.
72. The allegation that Dr Graham committed perjury in his evidence to the Tribunal, at the instigation of the LHB, is unsupported. It is of such seriousness that we would expect Dr Ojha's to have complained to Dr Graham before the hearing, raised the matter as soon as he saw Dr Graham's witness statement, and ensured that his counsel was in a position to cross examine Dr Graham with a view to obtaining the witness's true, as opposed to his arm-twisted, view. As it is the allegation was not put to Dr Graham and we do not know how he would have answered it. We find it wholly improper that Dr Ojha raised the issue in the manner he did, and we place no weight at all on the allegation. However, we do take into account that this is consistent with a frequent tendency to attack the author, rather than the substance, of criticism.
73. We accept that the LHB did ask the care home manager for written details of the concerns of the home and of the individual patients. Dr Holland denied that he had sought such information, but it is clear from the oral evidence of the manager that the concerns were put in writing at his request. We draw no adverse conclusions that they were not first put to Dr Ojha, nor indeed from the request itself. It was perfectly proper to obtain such evidence as part of the review of Dr Ojha's practice in light of the GMC assessment of 2011. We do not accept Mr Bull's description of what happened as "sordid", as it is perfectly proper and necessary to make enquiries for the purpose of fulfilling the LHB's duties to protect the public.
74. In any event we do not see how, unless the patients and the manager were themselves part of a conspiracy, which was not alleged, this would affect the content of the evidence.
75. The problem with the premises and the parliamentary complaint goes back a long way and is difficult to evaluate. At best, if we found evidence of recent bias, it would provide a clue as to when it started.
76. The allegation that things started to go wrong when Dr Holland became medical director contradicts, to some extent, the alleged long history of persecution. Dr Ojha had had no problems with his predecessor, Dr Southan. Apart from the denial that he sought to collect evidence relating to Dr Ojha, following the 2011 GMC assessment, which we do not accept, we were not

provided with any basis to conclude a systematic personal bias. Dr Holland gave what may or may not be a good explanation as to why relations with Dr Ojha broke down, but we consider that he had good reason to want to know when Dr Ojha would return to work, and this is not evidence of bias or pressure.

77. In his evidence Dr Ojha told the Tribunal about the circumstances of the sacking of a member of staff. His specific complaint was that the LHB had, through Rachel Way, put him under pressure to sack the person. She had then, he said, promised support in the Tribunal proceedings brought by the sacked employee. That the LHB did not produce witness statements in time for the Tribunal's deadline is documented fact. That an employer is primarily responsible for his own employment practice, whatever external advice is received, is, however, something which the Tribunal must take account of. That an Employment Tribunal can, for good cause, be asked to extend deadlines for receipt of witness statements is something Dr Ojha could have taken into account. Failure to provide a witness statement or to make a witness available without a summons is common and does not support an allegation of bias.
78. In this context, the heart of the complaint appears to be that the LHB appears to have changed its mind and withdrawn the previously offered support and assistance in the Tribunal. Rachel Way denied having offered such support. Dr Ojha says she offered it and then was put under pressure to withdraw it, and in her denial misled this Tribunal. As evidence of the veracity of his allegations he showed us a copy of a diary entry in which he made, he said, notes of a conversation with Ms Way. We looked at the original of the diary, and saw that from time to time Dr Ojha did use his personal diary in this way, but not systematically. As a reliable record of such an important meeting it is somewhat deficient. It could not be verified by Ms Way at the time, and given the substance of what was allegedly discussed, it would be expected that the nature of the LHB's involvement and support would be documented in an exchange of letters. We do not place significant weight on Dr Ojha's unorthodox and one-sided recollection. Although we would have concerns if the LHB did change its mind about providing evidence to the Employment Tribunal, this could have been remedied in any event by an application for a witness summons. It is exactly the same situation in which Dr Ojha found himself with his witness, Dr Southan, in the present proceedings. Dr Southan was not willing to attend and did not write a statement for the present proceedings.
79. Our overall assessment of the allegations of bias, in the context of a long and troubled relationship between Dr Ojha and the LHB, and given our findings, which we set out later, is that Dr Ojha is unwilling in general to accept shortcomings on his own part. We think it probable that the alleged bad faith has arisen in his mind as a way of explaining matters which are uncomfortable for him, but that he is wrong to confuse a difficult working relationship with

actual bad faith. We agree that at times mistakes were made, not least in relation to the overlong hearing, but we do not accept that there is credible evidence of a campaign or of systematic bias against him.

Respondent issue 1: Has doctor Ojha been given reasonable chance to improve and reasonable support?

80. Although this is a key finding Mr Hyam urged us to make, it does not appear, in Mr Bull's summing up, to be disputed that Dr Ojha received a great deal of support. Although Dr Ojha made some allegations that retraining following the NCAS assessment was "blocked", and that Dr O'Dwyer was not enabled to follow up the training delivered in 2008, the former was not substantiated by any clear evidence, and the latter was in fact explained by the evidence that the follow up was in fact provided by another doctor, not Dr O'Dwyer. Dr Ojha's evidence, that he paid fees of £22,000 to Dr O'Dwyer's practice for the supervised training he received in 2008, cannot lead to a finding that the level of support was not considerable, given that the training was organised by the Deanery and the LHB, and that the LHB's financial input was far greater than this sum, in that Dr Ojha received his salary during this period and the Crumlin practice was supported during his absence by locum input at the LHB's expense.
81. We are satisfied that Dr Ojha was indeed given a reasonable chance to improve and reasonable support up to the date of the GMC assessment.
82. Dr Ojha's complaint that the locum support was withdrawn too rapidly is difficult to accept, given that the restrictions on his return to practice had been removed, and he had been declared fit to return following an occupational health assessment.

Respondent issue 2: What deficiencies does Doctor Ojha accept in relation to past and present performance judgments and assessments?

83. Dr Ojha has been subject to a number of adverse judgements since 2003, and these are summarised in the outline of the respondent's case above. He was taken through each in turn during cross examination, in order to ascertain which criticisms he accepted, and which he did not. This, we agree with Mr Hyam, is of relevance to Dr Ojha's case in that Dr Ojha argues that, if we accept the GMC recommendations, he should have the opportunity of further training.
84. Dr Ojha was referred to a GMC reprimand in 2003. This, he said in cross examination, was a complaint which had originated in the practice he took over. He accepted the reprimand, but not the validity of the complaint.
85. He was then referred to a report to the LHB's predecessor, in which Dr Quirke, then medical director, had criticised his examination of patients. He said this was because at the time he was working in inadequate premises.

86. He was referred to a number of complaints made between 2002 and 2007. For the avoidance of doubt, we note that it was not alleged that Dr Ojha received a disproportionate number of patient complaints. The issue was whether he recognised, or denied, the validity of those complaints. He said none of the concerns were valid.
87. An NCAS report in 2006 had recommended no return to practice without further retraining. Mr Hyam took Dr Ojha through the specific headings under which the NCAS conclusions were recorded. Dr Ojha agreed that the criticism of his record keeping was probably valid, and that of his chronic disease management was valid. He denied the validity of the concerns under the headings of investigation and assessment; prescribing; examination; consultation; referral and delegation; and complaints handling. He accepted that maybe there were valid concerns in relation to leadership and management.
88. The GMC assessment of 2007 listed a number of concerns. Dr Ojha accepted that his performance was unacceptable in assessment, treatment, records and relationships but denied the validity of concerns in other areas.
89. Dr Ojha accepted that following this assessment he was recommended to receive supervised training in an advanced practice. He was referred to a knowledge test undertaken during this period, which Mr Hyam noted that he had failed. Dr Ojha correctly pointed out that there was no condition that he pass this assessment.
90. Dr Ojha accepted that during the period of his retraining he had received support from Dr Southan on behalf of the LHB, and the latter had recommended that he be allowed to return to practice, and referred to the GMC for a further assessment as required by the earlier GMC report. He was asked if he accepted Dr Southan's evidence that the latter was disappointed to learn that he remained deficient, in the conclusions of the GMC in 2011. He told us that he "did not completely accept this".
91. Asked to explain in detail what conclusions from the 2011 report he did not accept, he replied as follows.
92. Firstly, Dr Ojha stated that he did not consider that he had "failed" the knowledge test which the GMC had required him to take. This was because the word "fail" did not appear in the report. He thought he had done well in the test, but if the GMC said he had to resit it, then he would do so. He was willing to continue to improve his knowledge.
93. Secondly he did not accept the GMC panel conclusion that his relationships with colleagues and patients was unacceptable. Asked if he thought the panel's conclusion was unreasonable, or if they had triangulated the information received incorrectly, he said he was not saying that, simply that he disagreed with the judgement. He said when the question was put to him, that there was no substance to the criticisms that he had problems working with patients. He said of the evidence of Dr Huw Thomas, the GP locum who had given evidence of a breakdown in doctor-patient relationships, that he

had never heard anyone say anything like that before. He had had no contact with Dr Thomas and the criticism were "all fabricated". Asked if he was accusing Dr Thomas of acting in bad faith, he said "you can say that, I don't stand for it".

94. When it was put to Dr Ojha that some patients refused appointments if they knew it would be with him (evidence of Dr Thomas) he said he had never heard that accusation before. He was then referred to the 2007 GMC report in which a Mrs Williams had been a third party interviewee. He said he did not recognise the name, though he then, after being reminded of this fact, agreed she had been a senior receptionist in the practice. Asked whether he accepted that there was a similarity in the criticisms, and not to say whether he accepted the criticisms themselves, he answered by denying the validity of the criticism but did not answer the question as put. He went on to say that all of the criticisms were made by people acting under the influence of others: Mrs Williams was unhappy with her contract; Dr Thomas was working for the LHB and had only been at the practice a few weeks. He asked Mr Hyam, rhetorically, "do you accept her view rather than that of a qualified medical practitioner of over 40 years' experience?"
95. Dr Ojha was referred to further conclusions from the GMC. He denied the validity of the conclusions that the following areas were cause for concern: assessment of patients; treatment; maintaining good practice; and record keeping.
96. It is apparent to the Tribunal that Dr Ojha has not accepted the validity of the majority of the adverse conclusions reached in the course of GMC, NCAS and LHB assessments. It is the view of the LHB that this shows a lack of insight, and makes the giving of undertakings to the GMC problematic, since the GMC requires an insight into the deficiencies which a practitioner is required to address. We consider this argument below.
97. At this point it is sufficient to record as a finding of fact that Dr Ojha rejects the majority of criticisms made against him. These criticisms are made by bodies or individuals with a professional obligation to make the enquiries and assessments which took place, and to report honestly what they have found and what they conclude. We have already rejected accusations of bias. The possibility that all of these individuals and bodies reach conclusions which are highly internally consistent but are in the majority of cases simply wrong is, in our view, remote. We note that the opportunity to challenge GMC findings has not been exercised. We find it overwhelmingly more probable that the criticisms have at least some validity, and that the consistent refusal to entertain them is evidence of a worrying lack of insight and an deep seated defensive approach to examination by others of his own performance.

<u>Respondent issue 3: Are the conditions proposed by Dr Ojha for contingent removal practicable?</u>

98. Dr Ojha has given an undertaking to the GMC in respect of the steps he must take to remediate the problems identified in the assessment. He argues that if he is to be removed from the performers list, that removal should be contingent and the conditions should be those required by the GMC and contained in these undertakings. The LHB submits that the undertakings are not practicable.
99. Dr Ojha was unable, during cross examination, to suggest any conditions other than those suggested by the GMC. Indeed he asked Mr Hyam, in response to the question of what conditions he thought appropriate, what Mr Hyam wished to propose. As he has not proposed any conditions other than the GMC conditions, we must assume that it is Dr Ojha's case that these are the appropriate conditions. We do not have a signed dated copy but the evidence from Dr Ojha is that these have been submitted to the GMC.
100. The first condition is to notify the GMC of employment, and this will cause no problem.
101. The second is to agree to a workplace reporter at any time he is employed in the provision of medical services. Dr Ojha initially proposed, in response to the question of who this person should be, that his wife should carry out this role. She is senior partner in the practice, and we accept Dr Ojha's evidence that she is a colleague at work and a wife at home: in other words, their personal relationship need not necessarily be a bar to her performing this role. However Dr S Ojha has herself been subject to GMC suspension from practice; there is evidence (which we turn to below) of problems with the practice's record keeping which are not solely attributable to Dr Ojha, since entries made by Dr Ojha appear under Dr S Ojha's name. She has herself been the subject of a serious complaint partially upheld by the ombudsman. We have no evidence of her suitability as a workplace reporter, nor that she is acceptable in this role to the GMC, who have not been notified that Dr Ojha would seek her to be named. Dr Ojha has not provided any evidence that he has given any actual thought to her suitability. We are unable, on the available evidence, to conclude that she would be suitable or acceptable in this role.
102. Mr Bull in his submissions did not in any event propose Dr S Ojha as the workplace reporter. We were informed that the practice has now appointed a salaried GP, of some 15 years' experience, and Mr Bull's submission is that this person could perform the role. However, we noted that on two occasions, once in criticising Dr Holland, and once in relation to the evidence of Dr Thomas and Mrs Williams (above), that Dr Ojha emphasised the importance of respecting his more than 40 years of experience, and he appeared to us somewhat intolerant of contrary opinions from those with less experience. He has shown himself to be generally intolerant of criticism, and it would in that context be difficult for him to take advice and direction from a doctor of considerably fewer years' experience than himself. The qualifications and suitability of the new salaried GP are entirely unknown, as is her acceptability to the GMC in this role. We cannot, at this stage, draw any conclusion that

this person would be a suitable workplace reporter, or that Dr Ojha has given any realistic thought to the issue of how to comply with this condition.

103. Dr Ojha, under further cross examination, appeared to consider it would be the duty of the LHB to find him a suitable workplace reporter. This would, as pointed out by Mr Hyam, require him to be employed in a practice where such a person was also employed. Whether it is realistic to expect the LHB to arrange this is not for us to determine, but it is clear, at this stage, that Dr Ojha has himself not yet put forward any concrete proposals to name a workplace reporter.

104. The third condition would allow the exchange of information between the GMC and an employer or a contracting body. This should present no problem, though we bear in mind that Dr Ojha did not react well to such exchanges in the past, where his employees or LHB employees were criticised for such exchanges.

105. Undertakings 4 and 5 require the GMC to be informed of disciplinary proceedings or overseas employment and would not pose a problem.

106. Undertaking 6 represents perhaps the other substantive matter, and can be combined with undertaking 8. These together require Dr Ojha to work with the Director of Postgraduate General Practice Education to formulate a personal development plan. We know from Dr Ojha that this has been delegated by the Director, Dr Lewis, to his Deputy Dr Rice. We have seen Dr Ojha's personal development plan, which he says was worked out with Dr Rice. In evidence to support Dr Rice's involvement he produced a grid containing some handwritten comments in various sections, which he said was in Dr Rice's handwriting. These comments, he said, were then typed up to form what is now the PDP.

107. We consider the available evidence as to the support from the Deanery to be poorly presented, given the importance of such support, and we find it difficult to place weight on it. In considering Mr Bull's closing submissions, it is clear, if not in Dr Ojha's mind then at least in that of his counsel, that the goal at the Tribunal was to convince the panel that we should accept that there are issues of concern, but that the overall judgment of the GMC as to the necessary remedial steps was the right one. In those circumstances it was always to be expected that the Tribunal, if it was to agree to contingent removal, would need to look at Dr Ojha's proposals for retraining with great care. It appears to us – though it would have been helpful to have it confirmed or refuted by Dr Rice – that what Dr Rice wrote in the outline plan was no more than jottings which would enable Dr Ojha to begin work on his PDP. For example under the heading "What will I do" there is the entry in Dr Rice's handwriting "Comply with HB conditions which means no clinical contact" and below that "When appropriate comply with GMC conditions". The entries for "When will I do it" say, respectively, "ongoing unless conditions change" and "if HB allow clinical practice". There is no entry in relation to these two items under the heading "how will I do it?". We cite these as examples, but we have

studied the very brief table presented, both in handwritten form from Dr Price and the final version apparently now submitted to the GMC. We cannot conclude that it is a formulated, workable plan which will enable the Deanery and Dr Ojha to address the listed deficiencies in undertaking 6 in relation to working with colleagues; relationships with patients; assessment of patients' conditions; providing or arranging treatment; other good clinical care; maintaining good medical practice; and record keeping.

108. Our conclusion is that he has not put forward a workable personal development plan.

109. This conclusion is reached even before considering whether any plan is workable if a doctor lacks insight. On this issue we heard evidence from Dr O'Dwyer, who worked with Dr Ojha in 2008. Dr O'Dwyer said that previously Dr Ojha had been willing to learn and had accepted the need for improvement. Dr O'Dwyer said that it was common for a doctor in this circumstance to seek to reject the criticisms which had led to the retraining need, and the desire to learn was what mattered, even though denial of criticisms presented a barrier to improvement. Dr O'Dwyer offered this as a generic conclusion, not one in respect of Dr Ojha, who had previously appeared to be accepting of criticisms.

110. We now have evidence which shows that whatever he accepted in the past, the majority of the concerns voiced by the GMC, and indeed others, have now been rejected as unfounded. Given our conclusion that the personal development plan is in any event inadequate, we do not need to make an independent decision on the question of whether a lack of insight, if established in Dr Ojha's case, would prevent adequate progress in any event.

<u>Respondent issue 4: Did Dr Ojha fall below acceptable standards in relation to patient dignity?</u>

111. We were referred to two alleged failures under this heading. They both stemmed from complaints first raised by a care home manager, and which we now know were complaints not made until evidence was being collected by the LHB.

112. One patient, who has subsequently died, complained that Dr Ojha examined him while he was seated on a commode. Dr Ojha rejects this complaint. He says he would not see a patient in such circumstances. He also told us he had no specific recollection of the alleged consultation, and, further, that it might save such an elderly and immobile patient further discomfort if he could be examined without having to move. We have no reason to believe that a complaint of this sort would be manufactured by a patient at the bequest of the LHB, or that the care home manager would, at the LHB's instigation, pressurise the patient into making such a complaint. However, in the circumstances we cannot place significant weight on the allegation.

113. The other issue also arose in the care home. The witness could not attend to give her evidence, but her statement sets out clearly why she says she was unhappy with Dr Ojha's treatment. She says he examined her while she was in the residents' lounge, but from a distance. He remained in the doorway to the lounge, and questioned her in front of other patients. Clearly, if this is true, it is not acceptable. However Dr Ojha denies the truth of the allegation. As with the complaint in the previous paragraph, Mr Bull also points out that it arose at the same time as the other care home complaints, and there was no complaint until it was solicited. We can, again, see no reason why a patient would invent such a complaint, and do not believe there is the slightest evidence that this patient was pressurised into doing so. That an actual consultation of this sort took place is accepted by Dr Ojha, as he gave us evidence as to the appropriate treatment for this patient's swollen hand. In cross examination Dr Ojha said he had not recorded the consultation in the patient's notes, which is a matter of some concern in itself (see below), and in this context necessarily means he has no contemporaneous record with which to address the allegation. We conclude that there is, in this evidence, a cause for actual concern, on the basis that we feel the evidence does point to the occurrence of a consultation in circumstances where patient confidentiality was not respected.

114. We heard considerable evidence on whether the home's examination room was adequate. We were not asked to make actual findings on adequacy, and do not, in fact, consider that it would affect the above findings in any event, since a patient is entitled to be examined under circumstances which maintain her privacy and dignity.

<u>Respondent issue 5: was there a failure to adequately examine a patient?</u>

115. This allegation arose with a patient visited at home. The patient had an ulcerated wound to her leg. It had existed for a while and Dr Ojha was aware of it. She did not want to go to hospital. The dispute as to what happened is between Dr Ojha and the district nurse, Dorothy Alexander. Mrs Alexander told us that she wanted to attend the home together with Dr Ojha, as there was evidence of deterioration. Dr Ojha was not available and therefore other arrangements were agreed. Dr Ojha says it was agreed that Mrs Alexander would remove the old dressing and clean the wound, leaving it covered with a piece of kitchen paper, ready for Dr Ojha to attend and examine it. Mrs Alexander says that what was agreed was that Dr Ojha should see the wound first, take off the dressing which had been on overnight, examine the patient, and leave the wound covered with a piece of kitchen paper until Mrs Alexander could return to clean and dress it. The evidence we are invited to accept from Mrs Alexander is that without removing the dressing, Dr Ojha could not have carried out an appropriate examination. Dr Ojha's case is that

he did remove the dressing, and therefore such a criticism cannot be sustained.

116. While Mrs Alexander's evidence was clear that the wound remained in its old dressing after the visit of Dr Ojha, this is contradicted by evidence in the LHB's panel hearing where this issue was considered in detail. Mr Bull referred us to the parts of the transcript where the author of the enquiry report stated on several occasions that the nurse had removed the dressing before Dr Ojha attended. In this circumstance the respondent has not proved this allegation.

117. However, this attendance raised additional concerns. In his statement to the LHB panel, which was also his statement to the Tribunal, Dr Ojha denied making an entry in the records for this patient. He justified this by saying at paragraph 5 that this would indicate that there was no change in her condition. However, it was pointed out in cross examination that there is an entry for this incident, but it has been made under Dr S Ojha's name. Asked to explain this he said that this was a common problem if the record was already open under her name, and even if he logged on to the system using his own password it would default to the entry already open. He also told the Tribunal that the problem was a result of his using Dr S Ojha's computer on this occasion.

118. We have grave concerns that Dr Ojha gave two inconsistent versions of events in relation to this patient's record, in addition to concerns we consider later in relation to record keeping as such. Dr Ojha's answers to questions about whether there was a record of the consultation created an impression that he was willing to offer an answer which would meet the particular question, rather than giving an answer based on an actual recollection.

119. We also note that he initially volunteered little detail as to the actual examination he carried out, presumably because this would be consistent with the lack of need to make a record. When further questioned he gave a great deal of detail of his examination of the patient. We are not convinced this was based on his actual recollection, and consider that what he sought to tell us was what was appropriate by way of examination in such circumstances. We do not wish to imply that Dr Ojha did not examine the patient appropriately. We have explained why such a finding should not be made in the circumstances. Our concern is that he appeared willing to give evidence which he claimed was from a clear memory which contradicted his earlier lack of detail and claimed lack of reason to record the consultation at all.

120. We consider it a matter of concern that, whether or not he recorded the consultation, he would consider as a justification for saying that he did not do so that there is no need to make an entry in the record in such circumstances.

<u>Respondent issue 6: was there a deficient standard in complaint handling.</u>

121. Concerns with complaints handling have been raised on previous occasions, as noted in the issues referred to above in the cross examination of Dr Ojha. The particular concern here focuses' on one patient. That patient had been given the wrong prescription by Dr S Ojha. The incident itself is not relevant to the Tribunal, though out of respect for the patient, we do not wish to appear to minimise its importance for him. We heard evidence from this patient, the relevant part of which was that he was not satisfied with the way in which his complaint had been handled. The reason this relates to Dr Ojha is that at the relevant time he appears to have been responsible for handling complaints. We say "appeared" as a practice manager was also employed at that time. It was in any event Dr Ojha who first met the patient to discuss the complaint.

122. The matter was referred to the ombudsman, who made critical findings of the complaints handling at the practice, and ordered an apology. We have seen the apology issued in response to the recommendation of the ombudsman. We have heard the evidence of the patient who was wholly dissatisfied with it. It is written by the practice manager, but purports to be from and on behalf of Dr K and Dr S Ojha. The apology amounts to the following: "We would like to apologise to you with regard to the prescription error." There is then an undertaking by the practice manager to review policies on complaints and prescribing every three months. The prescribing error was a serious error, and the failure to address the complaint was itself a serious matter, requiring, in the end, a referral to the Ombudsman. In our view the wording of the letter, found at c81 of the bundles, issued by the practice was manifestly inadequate. It did not mention the name of the doctor concerned, explain how the error had arisen, or express any insight or concern into how the patient felt. We find it very surprising, and unacceptable, that Dr Ojha told us that in his view this letter was an appropriate response to the Ombudsman's recommendation to issue an apology.

123. We heard from the patient concerned that the practice had not provided him with any information about its complaint handling procedures, or guidance to the patient. However, the complaint was first made to the LHB, as is not uncommon, and from there it was referred to the practice. The patient also alleges the LHB failed to provide him with such information. Mr Bull made much of this alleged failure, but it cannot deflect the criticism from Dr Ojha himself. He has been subject to criticisms for his complaints handling on more than one occasion, and failures to inform a complainant about the procedures involved, and failure to ensure, at the least, that an apology ordered by the ombudsman is adequate, is a matter of concern.

<u>Respondent issue 7: was there a failure to work effectively with colleagues?</u>

124. Dr Huw Thomas was the salaried locum doctor supplied by the LHB, whose evidence to the Tribunal was that Dr Ojha's relationships with staff

were poor. Dr Ojha said in response that Dr Thomas had virtually no contact with him, and that Dr Thomas had never complained of this to him. Dr Thomas agreed that he had not complained, saying that this was not his role. Nevertheless, we find, a failure to communicate concerns to the person concerned would indicate, at least potentially, that Dr Thomas was not overly worried about the impact of the alleged bad relations.

125. What Dr Thomas said is supported in the GMC findings and also in the evidence of Ms Keyes and Ms Way. Specific examples were given by them of matters raised not only with Dr Ojha but also with the LHB. Dr Ojha insisted that these witnesses did not raise any concerns with him directly, which, if true, would be surprising. However the witnesses disputed this, Ms Way making clear that she saw it as her role not to raise matters of concern in front of others, but to do so privately, as she was in the practice for the purpose of providing support.

126. We can see no reason, having rejected Dr Ojha's allegations of bad faith, to see why these witnesses would lie about having informed Dr Ojha from time to time of concerns. In any event, the main concerns they raise, consistent with GMC and other concerns, is poor relationships with staff.

127. We saw for ourselves how Dr Ojha does not like to be challenged. He found it difficult under cross examination to answer questions which required him to respond to criticisms. He sometimes preferred to rely on his experience and authority to dismiss such questions, rather than answer them. Such an approach could be intimidating or worse to a member of staff.

128. While we cannot form clear conclusions at this point, we consider that the GMC, and now the respondent, are right to see this as an area in which Dr Ojha needs to improve.

129. Under this same heading Mr Hyam asked us to make findings in relation to Dr Ojha's relations with the Out of Hours Service, in relation to a specific incident about which we had both oral evidence and the testimony of Dr Peter Thomas. In our view the concern is not so much about relationships between professionals as it is about the way Dr Ojha is alleged to have determined how he, or others, should deal with a particular patient who needed attention at home.

130. The patient lived in a residential home. She was elderly. She suffered from diabetes. She was, we accept from Dr Ojha's evidence, well known to the practice. The out of hours service is responsible for seeing patients after 6.30 pm, and up to that time it is the responsibility of a surgery.

131. Dr Ojha says the care home phoned the surgery at 5.20 pm (evidence differed as to whether it was at this time, or earlier, but we have not been asked to treat this as of any importance) with concerns that this patient's sugar levels were giving concern. Dr Ojha in his statement says the following: "The District Nurse's notes in relation to diabetic patients are kept at the home and these do not generally require a signature by the doctor unless the use of syringe drivers is being authorised or there is a change in a dosage of insulin.

However, where the latter is authorised by telephone it would be unreasonable to expect me or any other doctor then to attend the home to sign the nursing note in question." Dr Ojha told us in oral evidence that the patient was on a sliding scale: the implication of this is that the patient's insulin dose can be varied without a change of prescription. He was asked to refer us to the part of the notes where this was shown, but instead pointed to a change of dose at an earlier date. We conclude she was not on a sliding scale, and any change in insulin would have required a doctor's decision.

132. It is now known and accepted that the patient's instability was probably caused by a chest infection, and when Dr Thomas attended as a result of the out of hours serviced being called by the home, what was required was not a change in insulin dose, but antibiotic treatment for this infection.

133. In any event, it is agreed that Dr Ojha did not attend.

134. In cross examination of Dr Thomas it was suggested by Mr Bull that this might not have been necessary because Dr Ojha knew the patient had had a previous chest infection. Dr Thomas did not agree that this could make a visit to the patient unnecessary. The cross examination was in any event predicated on the false premise that the patient was on a sliding insulin scale, which Dr Thomas said was not indicated in the patient records kept at the care home, and we now know is not the case having seen the patient record.

135. Although not raised in his statement, or when questioned at the LHB hearing, of which we have the transcript, Dr Ojha told the Tribunal that he did not say he would not attend this patient, and said that he had expected the home to call him at home, as they had his number. This expectation was not put to the care home manager in cross examination, and the latter said that she was told by Dr Ojha to call the out of hours service if necessary. We are surprised that this explanation has first been raised at this late stage, particularly as Mr Bull, when cross examining Dr Thomas, made a point of establishing that responsibility for visiting patients at home transferred to the out of hours service at 6.30 pm. We find this explanation difficult to place any weight on in considering the overall picture of what happened and what should have happened.

136. Dr Ojha's explanations for not visiting this patient, if we take account of matters also suggested in cross examination, comprise the following: the patient was on a sliding scale of insulin; the patient's chest problem was known to him; he had authorised a change of dose by telephone; or he would have visited out of hours. We do not find it possible to reach a conclusion as to what actually happened, and why he made the professional choice not to visit this patient. We are not satisfied that Dr Ojha has explained why he did not visit this patient. We do accept Dr Thomas' evidence, which led to him reporting this matter to the LHB, that in the circumstances a visit should have been made.

137. It is not alleged that Dr Thomas was part of any attempt to seek out adverse evidence. He told the Tribunal that he is not likely to have to report a

concern to the Board more than once or twice a year. He saw this as a matter of concern, as do we.

Respondent issue 8: was there a deficiency in relation to record keeping?

138. We have noted above that we find Dr Ojha's evidence in relation to whether or not he made a record of a consultation with a resident in a care home to be unsatisfactory. He was prepared to say making a record was not necessary, and then that he did make a record but that it accidentally occurred under Dr S Ojha's name, as she must have left that patient record open on her computer, and when he logged in in his own name, for some reason using her computer not his own, it defaulted to that open record.

139. The particular incident relied on by the LHB arose in relation to depression screening of a particular patient. We note Mr Bull's submission that the LHB should have checked with the patient what happened. However, while this may have provided more information, the issue of reliability of Dr Ojha's record keeping can be examined without such information.

140. This depressing screening automatically attracts QOF (Quality and Outcomes Framework) points and payment, if correctly recorded on the practice IT system, which we understand is the Vision 3 system. Dr Ojha stated, and we accept this, that the system automatically flags up the need to carry out depression screening in certain circumstances, and this arose in this particular case.

141. Most of what happened is agreed. Dr Lewis, who was responsible for auditing QOF reports, visited the surgery on 6 April 2010. In the course of the visit she identified an entry in the patient record showing that depression screening had taken place on 3 November 2009. The entry itself was shown as having been made on 30 December. She found no corresponding appointment on 3 November, and asked Dr Ojha for his explanation. Dr Ojha could not explain why there was no record of patient contact that day.

142. Dr Lewis looked again at the records on 11 April, and noted that the date now recorded for when the depression screening had taken place was 11 November, and the following words had been added: "At time of flu vaccine. Depression screening using questions. No both questions."

143. Dr Ojha's explanation to the Tribunal is as follows. He had no intention to deceive, since anyone could see that the entry was made on 30 December. He had made the entry when preparing for the QOF submission, which took place at the end of the month. What he had done was something he sometimes did when short of time, which was to make notes on paper rather than directly onto the computer, and carry out a "tidy up" from time to time. He had used this tidy up note, on 30 December, to complete the record of the depression screening. He could not produce this note now or previously because he had destroyed it, but he could show us a note of a similar type.

144. He told the Tribunal he had not been able to give an explanation to Dr Lewis without making checks. When he had gone through the appointments records after her visit on 6 April he had been able to recall that he had carried out the depression screening on 11 November, not 3 November, at the time of a flu inoculation clinic. He told us he carried out this clinic because a nurse was absent, so he had had to take over this clinic. However, he also told the Tribunal that the patient was booked to see Dr Huw Thomas on 11 November, and the latter had been away.

145. This had been an extremely busy clinic, he told us, allowing insufficient time to make a computer entry of the screening, though he remembered carrying out the screening.

146. We have seen the relevant record, and it corresponds with Dr Lewis' description. It also shows the consultation lasted two minutes. Dr Ojha was both examined and cross examined on how the consultation had taken place. He said that the depression screening would have required no more than asking whether the patient was feeling low, was he eating well? It was not necessary to go any further once the patient had said he was not depressed.

147. Later in cross examination he referred to following a set list of questions, which included asking the patient if he was not enjoying mixing with people, as well as the questions about eating and feeling.

148. Mr Hyam submits that the flu inoculation and the screening would have taken more than two minutes. Dr Ojha at one point suggested that the time for the consultation may not be accurately recorded, as it depends on when the computer button is pressed. This explanation suggests a problem with the integrity of the record as much as helping Dr Ojha to explain what happened.

149. There are a number of problems with the history given by Dr Ojha. We cannot understand why he could give no explanation to Dr Lewis, when he now says his monthly use of the tidy up record is normal. Knowing there was a concern with this, we cannot understand why he destroyed the note. We cannot understand why, relying on this note, he entered the wrong date of 3 November, since the note would be useless if it did not include dates of consultations. We cannot understand why it would take more time to enter onto the computer – a matter, we were told, of ticking the two boxes that automatically appeared on screen - that the depression screening had been carried out, particularly as the flu inoculation was recorded on screen and not on paper. It is not credible that a separate paper note saves time.

150. We cannot understand why the correction of the record did not take place until the end of December. The computer would still have indicated a need for screening every time that patient's record was opened, and no-one looking at that record would know that the screening had in fact been carried out.

151. We cannot understand why Dr Ojha now has a clear recollection of the screening, and the actual questions asked, when he could offer no explanation at the time of talking to Dr Lewis. We cannot understand why he

told us it was sufficient to ask a quick question to find out if the patient was depressed, and initially told us that he did not need to go any further when the patient denied it, and then, in response to later questioning, told us that he put a series of questions according to the protocol.

152. We think a far more likely explanation as to how the records came to be amended twice, with more detail being added about the flu clinic the second time, is that Dr Ojha's record keeping is inadequate, that he relies on his memory, which is not guaranteed to be accurate, and that he is content to defend as accurate a record which is not accurate and to state he has a clear memory when he does not. We stop short of endorsing Mr Hyam's submission that the record was fraudulently created to attract QOF funding, but we do so only because we conclude Dr Ojha is careless with his records rather than fraudulent.

153. The other specific incident relied on by the LHB arose from the evidence of Dr Naranayan. We did not have her oral evidence, so it was not tested under cross examination. However the salient points are not disputed. Dr Naranayan, a salaried GP working at the practice, spoke to a patient on the telephone on 21 January 2011. She decided the patient should be seen, and made a note in the patient record of that conversation, marking it as a telephone encounter. She made an appointment for Dr Ojha to see the patient later that day. Dr Ojha saw the patient.

154. Dr Naranayan at a later date was looking at the notes to see the outcome, and saw that Dr Ojha had added a record of his own consultation with the patient, but it appeared as a continuation of the record of Dr Naranayan's telephone encounter. In other words the record showed that Dr Naranayan and not Dr Ojha had seen the patient that afternoon and formulated the treatment plan. Her evidence is that she was disconcerted by this. She asked Dr Ojha to correct the record, and she reported the matter to Dr Holland. Dr Ojha told her she could correct the record if she wanted. That is what he also told us. Dr Naranayan says that she later checked to see if it had been corrected, and it had not, so she did indeed make her own correction so as to make clear which doctor had taken what steps.

155. Dr Ojha told us that he told Dr Naranayan that if she was unhappy with the record, she could change it. In essence, he accepts the accuracy of what she said.

156. We note that Dr Ojha has previously been criticised for his record keeping. We note that he has not only made entries under Dr Naranayan's name, but also accepts that it is a common problem that he and Dr S Ojha's entries can be confused. We are surprised that this can happen, since Dr Ojha's explanation is that he would log on using his own password, but if the same patient record was already open, the computer would default to the practitioner who had opened that record, despite the change of log-in. Dr Holland described with some precision in his witness statement (paragraph 57) how this system works. After 20 minutes inactivity, the user must enter a

password. When a patient record is opened, it defaults to a new consultation. Changes to an existing consultation are audited, which means the name of the person making the alteration is indicated. Dr Holland was not challenged on this evidence. If we accept that this is how the system works, then it is inconsistent with what Dr Ojha says is the explanation for him making entries on patient notes which show up as being made by another practitioner.

157. We accept Dr Holland's evidence. He appended an email from the Board's IT specialist confirming his understanding. Dr Ojha's explanation is therefore unconvincing. Even if it were true it would be unsatisfactory. The integrity of patient notes is of such obvious importance that he should have been extra vigilant to overcome the problems he claims he had with the system confusing his consultations with those of Dr S Ojha. It remained his responsibility to maintain accurate records. We also find his double alteration of a record to show depression screening took place several weeks previously, even if we were to accept his explanation as to how it happened, shows a failure to ensure the accuracy at any given time of his patient records. Even on his explanation as to the creation of the record, it would have remained inaccurate as to the date if Dr Lewis had queried it.

158. We find that Dr Ojha's record keeping, and his attitude to errors which were uncovered, are unacceptable. That attitude is epitomised in his comment, to the Tribunal, when he said he told Dr Naranayan that she could correct the record if she was unhappy. The refusal to take responsibility for this record was a denial of his own professional responsibility.

<u>Respondent issue 9: were there valid concerns over the treatment of a patient with a chronic heart disease?</u>

159. The specific issue of concern to the LHB was whether Dr Ojha advised a patient recorded as having long-standing ischaemic heart disease of the risks of long term use of non-steroidal anti-inflammatory drugs (NSAIDs). The patient record was selected for the GMC performance review, and was not the subject of a complaint. However it was of such concern to the GMC assessors that they wrote to the practice to ensure that the advice and medication be reviewed. The specific concern was that when the patient came in for a review with the practice nurse, on 5 January 2011, he had also been seen by Dr Ojha. Dr Ojha did not record in the patient record that he offered advice as to the risk of long-term use of NSAIDs. His explanation to the Tribunal is that in the case of a long-standing patient, that advice would have been given on previous occasions, firstly when the NSAIDs were prescribed by the hospital then treating him, and in any event by those who otherwise saw him in the practice.

160. We note that the patient's records of consultations do not show that such advice has been given. Dr Ojha's explanation to the Tribunal was that the patient had been referred to him by the practice nurse; he had seen the

record, that the patient had seen a cardiologist and a nurse, and no-one had ever raised a concern about the use of NSAIDs. He then said "I had impression it must have been explained to him". Asked if it was not his duty as a GP to explain the risk, he said that would only be the case with a new patient, not one being seen by secondary care and other staff.

161. We find the LHB was right to be concerned over this issue. It is an inadequate explanation for his acknowledged failure to explain risk to the patient that someone else would have done so, particularly were this could not be confirmed in the patient record. The absence of evidence that risk had been discussed with the patient, far from being a reason not to advise, should have led him to realise that the advice should be given and recorded.

Respondent issue 10: has Dr Ojha failed to prescribe appropriately?

162. This issue related to a failure to follow NICE guidelines in the prescription of penicillin and amoxicillin. We deal with this issue briefly. In the examples given, Dr Ojha was able to explain the difference between using penicillin, as advised, for a sore throat, but amoxicillin in cases where there was a secondary infection, as the evidence showed there was in the patient concerned.

163. However, we note with concern that when asked by the Tribunal if he followed NICE or LHB guidelines, he said he would rely on his own more than forty years of experience to decide whether they should be applied or not.

Conclusions

164. The outcome sought by the LHB is removal on grounds of unsuitability. On behalf of Dr Ojha Mr Bull says that the GMC recommendations should be respected, which means contingent removal.

165. Removal on grounds of unsuitability requires us to take into consideration the mattes set out in Regulation 11(2), which in the present case include: the nature of any investigation or incident; the length of time which has now elapsed; action taken by a regulatory or professional body; relevance of any incident or investigation to performance of a primary service; and risk to patients or public finances. In addition we are to consider the circumstances surrounding removal, contingent removal and suspensions of the performer. All of these matters have been considered above.

166. It is our view that the criteria for unsuitability have been established. We accept on behalf of Dr Ojha that he is well qualified and has considerable experience. We accept the positive testimonials received from two patients. We accept that the level of patient complaints and migration from the practice, even in the care home from which a number of complaints were received, does not give cause for concern. We accept the QOF scores which Dr Ojha gave the Tribunal, which give no cause for any concern.

167. We also accept that during the much of the period under consideration Dr Ojha was subject the dual burden of being a practising GP and a practice manager. However in relation to the discussion on suitability we are unable to place significant weight on this factor. A GP must not allow such responsibilities to interfere with his or her duties.

168. We accept that the opinion of the GMC that he is fit to practise subject to conditions carries considerable weight. We also accept that some of the matters considered by the GMC were based on information supplied by the LHB or the witnesses to the Tribunal hearing, and that to the extent that there are adverse findings in the GMC report, the challenges to the evidence put forward in the Tribunal hearing would apply equally in the GMC investigation.

169. However, as well as asking us to trust and rely on the judgements of the GMC, Dr Ojha's evidence, and Mr Bull's submissions, indicates that that many of the findings of the GMC assessors are refuted. We should not trust those findings. We understand why Mr Bull had to take this approach, but it undermines the argument that the GMC, as the professional body, should be followed. We note that Dr Ojha could have challenged the GMC findings, and that he chose not to. Instead he challenges many of them in this Tribunal.

170. In any event, we cannot be bound by the GMC conclusions, which would be an abdication of our duty under the legislation; we must evaluate the evidence ourselves and consider the matters to which the Regulations direct our attention. In addition we must take into account matters occurring since the GMC assessment in 2010.

171. We also take into account the GMC and Royal College of General Practitioners guidance in relation to standards.

172. We have set out our findings on the issues selected for our particular attention in Mr Hyam's final submissions. We conclude that it in relation to maintenance of patient records; attitude to his deficiencies and to the judgements of colleagues and maintenance of knowledge, Dr Ojha has shown himself to be unsuitable to remain on the respondent's performers list. While deficiencies in knowledge can be remedied, in Dr Ojha's case they are to be viewed in the context of previous failures.

173. While not in themselves demonstrating unsuitability, we find this conclusion is underpinned by other factors: Dr Ojha's general refusal to accept responsibility for problems or errors in his or his practice's performance; his unwillingness to accept as valid the opinions reached by others with which he does not agree; and his willingness to accuse others as acting in bad faith when the evidence does not substantiate the accusations, or in many instances does not even give rise to the possibility of such an accusation having any foundation. This is shown most starkly in his accusation of what amounts to perjury against a professional colleague, for which no credible evidence was offered. Dr Ojha's firm belief that his experience allows him to override NICE and LHB guidelines, in the context of the above concerns, give further cause for concern. We are equally

concerned by his evidence that it is acceptable for a patient in a care home to be given medication issued in the name of another patient, and that care home staff should take and supply him with details of residents' blood pressure. He refused in the hearing to accept the validity of care home guidelines to the contrary. All of these matters provide additional support for the finding that he is unsuitable to remain on the performers list.

174. We would, were we not to make a finding of unsuitability, have found the efficiency ground satisfied. We summarised above the help Dr Ojha has received from the respondent, and we are aware of some but not all of the cost incurred. Dr Ojha still cannot practise without further retraining and supervision. Some of this cost will be met by himself, but the LHB or the Deanery will have to provide supervision, appraisal, guidance and possibly at a later stage cover. Efficiency must take into account the expected gains to the NHS in devoting further resource to Dr Ojha's remediation. Despite intensive support which was agreed to have enabled him to achieve the required level of competence, the GMC assessment was accepted even by Dr Ojha's own witnesses to have been disappointing. Dr O'Dwyer said that the evidence speaks for itself. The LHB is justifiably concerned that further help will still not have the result that Dr Ojha will reach an acceptable standard in all domains. We agree that to keep Dr Ojha on the performers list would be indeed prejudicial to efficiency, and in addition, for the reasons set out in this paragraph, contingent removal would be inappropriate, since no conditions would be expected to have the result of removing that inefficiency. He has in any event not put forward workable proposals.

175. For the same reasons that we consider Dr Ojha to be unsuitable to remain on the performers list of the Aneurin Bevan Health Board, we consider him to be unsuitable to be entered onto the list of any other Board, and we order national disqualification.

Decision

176. The appeal is dismissed

177. Dr Kamlesh Ojha is removed from the performers list of the Aneurin Bevan Health Board on grounds of suitability and of efficiency.

178. A national disqualification is ordered.

Tribunal Judge Hugh Brayne

3 May 2012

Health Education and Social Care Chamber
First Tier Tribunal