Case No. 15319

FIRST TIER TRIBUNAL PRIMARY HEALTH LISTS

28 February 2011

Mr D Pratt	**Tribunal Judge**
Dr S Ariyanayagam	**Professional Member**
Ms C Wortham	**Member**

BETWEEN:

DR SYED ALIJAH
(GMC Reg No. 1418682)

Appellant

-and-

NHS COVENTRY PRIMARY CARE TRUST

Respondent

DECISION WITH REASONS

1. This is an appeal, dated 25 October 2010, by Dr Syed Alijah (Dr Alijah), a General Medical Practitioner, against the decision of NHS Coventry Primary Care Trust ("the PCT") contained in its letter dated 28 September 2010, to remove him from its Performers' List ("the List"). That decision was made pursuant to Regulations 10 (4) (a) and (c) of the NHS (Performers List) Regulations 2004, as amended ("the Regulations")[1] on the ground that inclusion in the List would be prejudicial to the efficiency of the services which those included in the list perform ("an efficiency case") *and* on the ground that Dr Alijah was unsuitable for inclusion on the List ("an unsuitability case").
2. By its Response to the Appeal the PCT applies to this Tribunal under Regulation 18A of the Regulations, for an Order for National Disqualification of the Appellant.

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[1] Regulation 10 …
(3)The [PCT] may remove a performer from its performers list where any of the conditions set out in paragraph (4) is satisfied.
(4) The conditions mentioned in paragraph (3) are that –
(a) his continued inclusion in its performers list would be prejudicial to the efficiency of the services which those included in the relevant performers list perform ("an efficiency case").
….
(c) he is unsuitable to be included in that performers list ("an unsuitability case").

3. The appeal was heard on 28 February 2011 at the Civil Justice Centre, Priory Court, Birmingham. The PCT was represented by Mr P Gray of Mills & Reeve, solicitors. The Appellant did not appear and was not represented. We refer to the section of our decision under "Preliminary matters" for an account of how this came about.

DECISION

4. Our unanimous decision is that:
    i. this appeal is dismissed and we direct that Dr Alijah's name be removed from the Performers' List of the PCT, and (2) Dr Alijah shall be nationally disqualified.
    ii. a National Disqualification shall be imposed on Dr Alijah, under Regulation 18A (2) of the Regulations, effective from the date of this Order; and the period after which Dr Alijah may apply for a review shall be the period of two years specified in Section 159 (8) of the National Health Service Act 2006.
    iii. A copy of this decision shall be sent to the Secretary of State for Health, the National Assembly of Wales, the Scottish Executive, the Northern Ireland Executive Committee and the Registrar of the General Medical Council.

The relevant legal framework

5. This appeal is brought pursuant to regulation 15 of the Regulations, by virtue of which it proceeds by way of a redetermination of the PCT's decision, and this Panel may make any decision which the PCT could have made.
6. We have set out above Regulation 10 insofar as it relates to the power to remove Dr Alijah from the Performers List. Regulation 11 of the Regulations sets out the criteria for removal in cases of unsuitability and efficiency, and we have had regard to those and to the Department of Health Guidance, while not limiting our consideration of factors to those mentioned in the guidance, and we have considered all the factors urged on us in this appeal.
7. Regulation 12 gives us a discretion to remove Dr Alijah contingently from the Performers List, subjecting him to conditions. This power is limited to the case on efficiency: if we find him to be unsuitable, we have no discretion to remove contingently. Contingent removal requires that we impose such conditions as we may decide with a view to "removing any prejudice to the efficiency of the services in question": regulation 12 (2) (a).
8. In our view the burden of satisfying us that the case is proved, lies on the PCT. We invited the PCT to lead the evidence on which it relied and in the absence of Dr Alijah the Tribunal questioned the PCT's witnesses and heard from Mr Gray on its behalf.
9. The standard of proof which we have applied is the balance of probabilities, whether a fact or allegation is more likely than not to have occurred, in accordance with the decision of the House of Lords in *Re D* [2008] UKHL 33.The Tribunal recognises that some events are inherently more likely than others.

Background

10. This appeal concerns multiple allegations by the PCT, which can be broadly summarised as follows:
    Efficiency -

Poor recording of patient history and inadequate patient examination
Lack of awareness of up to date clinical practice
Poor clinical judgement
Poor IT literacy and inability to communicate effectively
Infrequent recording of management plans and no recording of follow-up arrangements
Inappropriate prescribing.
Failing to attend booked surgery sessions.

Unsuitability –

Lack of insight into his deficiencies or, therefore, any realistic likelihood of Dr Alijah taking effective action to remedy them.
Conduct including inappropriate contact with patients during his period of suspension while these matters were being investigated.

11. Dr Alijah is a General Medical Practitioner who has worked in Coventry for about 30 years. As at September 2010 he was aged 70. He is on the Performers' List of, and holds a PMS contract with, Coventry PCT. He practises from premises known as Foleshill Medical Centre with a NHS patient list of 3,350 as at 1 April 2010. The area is one of socioeconomic deprivation and the patient population is predominantly south Asian. He has been in partnership with Dr Haider since May 2009. Each doctor has on average 650 consultations with patients each calendar month.
12. Dr Alijah was suspended on 24 December 2009 because he had failed to attend a number of pre-booked surgeries without giving notice to the Practice, and in order to allow an investigation of concerns about his health and clinical competence.
13. At the request of the PCT, Dr Alijah was assessed by two Consultant Psychiatrists and underwent an Occupational Health assessment. We are told that these assessments concluded that there were no health issues and Dr Alijah was medically fit to practise, but we have no other details about them.
14. The investigating officer was Dr P J Barker, the PCT's Associate Medical Director (poor performance) since 2006. Among the areas investigated, Dr Haider was asked if he had any concerns about Dr Alijah's clinical practice. He did, and these concerns (together with relevant patient records) were provided to Dr Alijah on 10 May 2010. He was interviewed about them on 7 July 2010. Six out of the 10 patient concerns raised by Dr Haider were considered by the PCT to be serious and were discussed with Dr Alijah. A note of this interview appears at pages 91-97 of the bundle provided for this hearing by the PCT pursuant to the Directions of the Tribunal. Dr Alijah received advice and support from his medical defence organisation at that stage and through them provided further written responses to the matters raised in interview on 7 July 2010.
15. Two audits of clinical records relating to Dr Alijah's surgeries were carried out, on surgeries selected on a random basis. One was by Dr D Barrett, a Coventry GP in an area of deprivation with a multi-ethnic population who is also an experienced assessor for the Quality and Outcomes Framework ("QOF") and for the Information Management Technology. His report appears at pp 48-52 of the hearing bundle and his witness statement at pp 40 -51. The other was by Dr R Jones, a GP for 20 years who has been a GP Trainer and Appraiser for 6 years. His report appears at pp 36-39 and his witness

statement is at pp 30–35 of the hearing bundle. Two of these cases were alleged to pose an unacceptable clinical risk to the patients concerned.

16. The other investigative steps and findings are set out in the report dated 26 July 2010 which was submitted to the PCT by Dr Barker and which also identified evidence of extremely late arrival and non-attendance at surgeries in 2009, and allegedly concerning responses to the matters raised at interview about the various clinical issues. It was also alleged that Dr Alijah had provided no evidence of undertaking Continuing Professional Development prior to his suspension in December 2009. On 19 March 2010 he sent a letter to Dr Barker [p 100 of the hearing bundle] claiming that he was unable to undertake his usual CPD arrangements because of the restrictions of his suspension, and was therefore left with medical journals only.
17. During the investigation the PCT received a letter dated 10 May 2010 from 4 members of staff at the practice [p 98 of the hearing bundle] alleging that Dr Alijah had been seeing patients during the period of his suspension, and had telephoned to require staff to prepare a prescription for a named patient.
18. The Oral Hearing Panel of the PCT considered the matter on 27 September 2010. The Minute of that Hearing is at pp 62-80 of the Hearing Bundle. It is not an agreed document, but nor has Dr Alijah challenged its accuracy. Dr Alijah attended that hearing and was represented by Mr R Privett an experienced solicitor of Messrs Radcliffes LeBrasseur, who questioned Dr Barker and made extensive submissions but did not call Dr Alijah to give evidence. However Dr Alijah did personally respond to various questions raised by the Oral Hearing Panel.
19. The Panel's decision was to remove from the Performers List and written notification of that decision was contained in its letter to Dr Alijah dated 28 September 2010.

Preliminary Matters

20. On 8 November 2010 Dr Alijah attended (representing himself) a telephone Case Management Directions Hearing at which Judge Burrow made Directions set out in his Order of 8 December 2010. Among other things they required Dr Alijah to prepare a bundle of the medical notes he wished to rely on and serve it on the PCT by 24 January 2011. By the same date he was required to serve his own witness statement and other witness statements and documents (including any expert evidence) he wished to rely on. The PCT was to serve its witness statements and documents by the same date. Dr Alijah was directed to notify the Tribunal by 24 January 2011 if was to be represented [he having indicated he might be represented].
21. On 26 January 2011 the PCT's solicitor wrote to Dr Alijah (copied to the Tribunal) stating that he had failed to comply with these directions. No application was made by Dr Alijah for an extension of time, nor did he contact the Tribunal or the PCT. The Tribunal Judge appointed to hear the appeal considered the matter and issued a further Order and Directions on 9 February 2011, which (among other things) noted the failure to communicate with the Tribunal or seek an extension of time and ordered that unless Dr Alijah served the various statements and documents referred to above by no later than 4.30 on 17 February 2011, he would be debarred from adducing or relying on such evidence at the hearing of the appeal, save to the extent that the Tribunal may permit him to give oral evidence on his own behalf. Permission was given to apply to set aside this Order or apply for further

Directions. No such application was made, but Dr Alijah failed to comply with the further Order, and no witness statements or other documents have ever been served by him.

22. However, at the request of the Tribunal Judge the Tribunal office contacted Dr Alijah by telephone on 22 February to enquire about his intentions, and he indicated to the administrator that he was unfit to attend and wished to adjourn the hearing. He was advised to obtain medical evidence and to submit an application to adjourn, which he did by email later that day. He also submitted a short letter (erroneously dated 24 February 2011) from his own General Practitioner, Dr K S Francis, which stated:

> "Dr Alijah has been under a lot of pressure following suspension from his own practice for sometime. Recently he suffers more from his COPD [chronic obstructive pulmonary disease] and his right eye. He was suffering from eye problems and thereby he is unable to read properly, The stress makes him more problems to concentrate and he does not take any medication for anxiety problems."

23. At short notice a telephone Case Management Directions Hearing was therefore arranged for 24 February 2011, at which Dr Alijah asked for the hearing to be adjourned for one month. He was asked to expand on his reasons for seeking an adjournment. He did not rely on either COPD or eye problems but said he had been unable to bring himself to open or read the documents in the hearing bundle which he acknowledged he had received, because of mental turmoil occasioned by his treatment in connection with his suspension. However he also said that he had papers all over the place, and must therefore have opened them. He said he was not up to attending the hearing. Sometimes he did not even want to go out. He indicated he felt unable to give attention to his affairs, but did not otherwise give a reason for failing to comply with the successive Directions of the Tribunal (which he also acknowledged having received) or for failing to seek any extension of time for compliance. He was asked what reassurance he could give that his situation would be any different in one month, and said he hoped it would but could give no reassurance. Although he had visited his GP he did not consider he needed treatment or medication and had no plans to take any. He was asked what steps he had taken to obtain representation to assist him in preparing his case, as he had indicated to Judge Burrow he may do at the Directions hearing in November 2010. He had taken no steps but thought he might still be able to do so. He put forward no reason for being unable to seek or obtain professional help.
24. The PCT opposed the application, and drew attention (among other things) to Dr Alijah's persistent and comprehensive failure to comply with any Tribunal Order, or to do anything to advance his own appeal. This application was not supported by the medical evidence produced. Moreover Dr Alijah had demonstrated during this telephone hearing an apparent capacity to understand the issues and engage in argument. It was suggested he had an interest in prolonging the arrangements under which he received significant remuneration while suspended.
25. The Tribunal Judge dismissed the application to adjourn the hearing. He was satisfied that Dr Alijah had received and understood the Orders made, but was not satisfied that Dr Alijah was unable or unfit, because of claimed ill health, to attend the hearing. The letter produced [see above] did not state

that Dr Alijah was unfit to attend the hearing, and to that extent did not support the application. Nor did it put forward any diagnosis of psychiatric illness although it suggested “anxiety problems” for which he did not take any medication. That did not suggest any disabling problem. During the course of the telephone hearing Dr Alijah was alert to issues, and able to speak and argue cogently, indeed was difficult to interrupt. No physical problem was relied on by Dr Alijah, despite the reference in the GP letter to two conditions.

26. Even if it were possible to spell out of the medical evidence some support for the proposition that Dr Alijah was currently unfit to attend the hearing, there was no evidence from which the Tribunal could identify a date or time by which he would be sufficiently recovered, and indeed it was clear that Dr Alijah would not be undergoing any form of treatment meanwhile. If so, there was potential unfairness to the PCT in adjourning the matter.
27. The Tribunal also took into account that this application was made at the last minute as a result of being contacted by the Tribunal, following a period from 8 November 2010 to 23 February 2011 when Dr Alijah had failed to comply with any of the Directions made at the telephone hearing he himself attended, failed to seek any extensions of time or otherwise to contact or respond to either the PCT or the Tribunal. The application to adjourn appeared to be prompted partly by this failure to take any step to prepare his own case. There was no persuasive evidence that Dr Alijah had been prevented by ill health from complying with the Tribunal Directions or applying for variations or extensions of those Directions. As a result costs had been incurred and the PCT was in a position to proceed in the hearing date.
28. Dr Alijah was informed that the Tribunal hoped he would attend the hearing either in person or with representation and in the former case the Tribunal would assist him to put questions and as far as it properly could. However on the morning of the substantive hearing a telephone message was received by the Tribunal office from his wife to say that Dr Alijah was in bed and would not be attending.
29. On 28 February 2011 the Tribunal therefore considered as a preliminary matter whether to proceed in the absence of Dr Alijah, applying the criteria set out in Rule 27 of the Tribunals Procedure (First Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 [“the Rules”]. In light of the failed application to adjourn this hearing date and the information given by Dr Alijah to the Tribunal Judge (see above) the Tribunal was satisfied that Dr Alijah had been notified of the hearing. It further concluded that, taking into account the matters set out at paragraphs 23 to 28 above, it was in the interests of justice to proceed with the hearing. There was moreover no evidence on which the Tribunal could estimate when Dr Alijah might feel able to attend a future hearing, whereas the PCT would be unfairly put to the expense of a further attendance with professional witnesses taken from their other duties, and meanwhile continue to make significant payments to Dr Alijah and pay the cost of locum replacements while he remained suspended.
30. Mr Gray, on behalf of the PCT, made, but then withdrew, an application to strike out the appeal, and the Tribunal decided to hear and determine the appeal on the evidence available. Mr Gray made clear that the PCT placed no reliance on an earlier unrelated suspension to which there is reference in the papers.

Evidence for PCT

31. The Tribunal had available the following documents:
    i. Hearing Bundle produced by the PCT with pages numbered 1-164 [hereafter referred to as "Respondent Bundle", or "RB"];
    ii. Bundle of copy patient records relating investigation.
    iii. Copy of the letter of suspension sent by the PCT dated 24 December 2009.

    We excluded from our consideration, and attached no weight to, the email which appears at page 109 of the Respondent Bundle, because it is from an anonymous sender, raised issues of personal conduct which are different in character to the substantive matters we are otherwise invited to consider, and is very general so that it would be difficult to test or place reliance on it.
32. It also heard evidence from:
    i. Dr Peter James Barker. DRCOG, DGM, MBChB, MFPPHM, who is the PCT's Associate Medical Director (poor performance in independent contractors) and has held that post since 2006;
    ii. Dr Robert Jones, MBBS, DRCOG, MRCGP, a GP trainer and appraiser who carried out a review of a sample of Dr Alijah's clinical records from clinics held on 6 January 2009 and 20 March 2009.

    We heard that evidence as sworn testimony, having regard to the absence of the Appellant, and the Tribunal also questioned the witnesses. We did not hear oral evidence from Dr David Barrett, who performed the second review of sample medical records, as he was unable to attend because of ill health. Having regard to the notice of the content of his witness statement given to Dr Alijah, without comment from him, we agreed to admit and read Dr Barrett's statement [pp 42-47] and associated report, subject to weight.
33. Mr Gray first directed our attention to certain documents in the bundle, starting with the Opening Statement [pp 1-9]. He directed us to the evidence at tabs 25-29 evidencing among other things Dr Alijah's non-attendance at booked clinics. An email dated 8 December 2009 from Yasmin Kouser (Dr Alijah's Practice Manager) to Margaret Johnson (Primary Care Contracting Manager) states that for the second time staff were unable to get hold of Dr Alijah. His mobile phone was switched off, and he did not have a land line where staff could reach him. This was the second time he had failed to turn up and staff could not reach him [the first being 24 November 2009 – see p.107], so that waiting patients had had to be sent home. Ms Kouser's email is timed at 5.06 pm, and Dr Alijah's surgery was due to start at 3 pm. She writes that patients were frustrated shouting and some had gone home.
34. When Ms Kouser asked Dr Alijah the following morning why he did not respond to her messages he is said to have replied: "I am 70 years of age, and it is mean of you to ask me to work!" [see p 107]. The same email dated 14 December 2009 [107] speaks of his being typically late: "today is a perfect example, surgery had started at 3 pm I even rang Dr Alijah he said he would be here and he has arrived at 5 pm. Four patients have already left". On 15 December Margaret Johnson received a voicemail from one of Dr Alijah's patients complaining that he had not turned up at surgery by 5 pm when she was in fact seen by Dr Haider, and this was not the first time it had happened. 5 other patients had left without being seen. At page 111 is a record made by a Complaints Officer of the PCT on 22 December that a patient identified only

as “patient X” and aged 62 had waited 1 ¼ hours to see Dr Alijah before deciding to leave because it was getting dark.

35. Mr Gray referred us to Dr Barker’s report at Tab 24 [p 103] for the background to the suspension and subsequent audit undertaken by Drs Jones and Barrett. He invited us to note that it had been necessary to have 2 patients recalled to be seen by Dr Haider, in view of the concerns about Dr Alijah’s management of their cases.
36. Dr Barker had interviewed Dr Alijah on 7 July 2010 [pp 91 – 97]. Mr Gray submitted that he had provided no adequate explanation for his repeated lateness or non-attendance, nor responded adequately to the concerns about the six patients highlighted by Dr Haider, of which he had had ample notice.
37. Mr Gray took us to page 98, a letter dated 10 May 2010 submitted during the investigation by 4 staff members at Foleshill Medical Centre, namely Ms Asha Mashi (Practice Supervisor), Mr Rind (Administrative Staff), Ashs Devi (Senior Receptionist) and Taslim Akhtar (Senior Receptionist) setting out their concerns that Dr Alijah was continuing to see patients during his suspension from the List and had applied pressure to get them to arrange for a prescription to be issued to a patient. Specific events on 6 and 7 May 2010 were described.
38. Mr Gray submitted that for contingent removal to have any prospect of success (assuming the legal conditions were satisfied) the Tribunal would need to be satisfied that Dr Alijah would give his co-operation and would be willing to engage and fully acknowledge his shortcomings, showing insight into what they were. In fact, he submitted, Dr Alijah lacked any insight. He place reliance on the whole period from his initial suspension to today to show that there was a lack of engagement by Dr Alijah.
39. Dr Peter James Barker gave evidence on oath. He produced his statement and confirmed its accuracy. He said he was (in addition to the post described above) a Consultant in Public Health at the PCT and was the investigating officer in this matter. He had selected the two independent GPs to perform audits. Both were experienced in the field, appropriately qualified and objective. Dr Barrett dealt with a similar patient population. He described the summary at page 91 of the discussion with Dr Alijah (7 July 2010) as an accurate summary, which set out pre-prepared questions, and noted the responses. He referred to the explanation at p. 91 given by Dr Alijah for his lateness and non-attendance: problems at the surgery at the time, his lack of enthusiasm for work and that it was a good opportunity for Dr Haider – if he could cope it would be good experience. But it was the wrong approach. He nevertheless said that the interests of his patients were of prime importance to him, and he had rung each patient whom he did not see, and had finished his surgeries eventually. As to the non-attendance he offered a variety of reasons: “ a big disaster…both phones failed….my wife was not with me that day ….the staff were not helpful ….the staff did not ring anyone to find me …. Me dozing off.” Dr Barker said that there was still no satisfactory explanation.
40. Dr Barker turned to the clinical concerns raised by Dr Haider. He personally reviewed those records, and on the questions about Patients A to F at pages 92 – 96 flow from that. We re-read Dr Alijah’s replies and explanations with care.
41. Dr Barker also expanded on his question about what Dr Alijah knew of the reason for his suspension. He said that although Dr Alijah had appeared

uncertain in his reply, Dr Barker had personally delivered the suspension letter to his house and had explained the reason and the effect of suspension on him. He had said that the suspension was because of risk to patients and to allow the investigation to go forward in a way which avoids interference with the evidence. Therefore he would not be allowed to see patients or attend the premises of Foleshill Medical Centre. Dr Alijah claimed not to have had any interaction with patients [see p. 96] but the letter from staff in May [see p. 98] contradicts this. In Dr Barker's view it constituted clinical interaction to visit a patient at his home and give medical advice on the patient's condition and on the nature of the prescription he would need for an eye condition.

42. He was asked about Dr Alijah's insight. He said he had found no insight at all over several issues such as his extreme lateness, nor any reassurance it would not happen again. In order for the PCT to engage with a practitioner the doctor must understand clearly the reasons why the PCT was unhappy with his performance or behaviour and be willing to co-operate with it on any remedial action. He often worked with practitioners who were seeking to improve (but had little experience of doctors subject to contingent removal). Most were done informally but it usually involved an action plan and follow-up with a mentor. This had been considered in Dr Alijah's case but the gross lack of insight meant any attempt would not work in practice. He had failed to take the whole situation seriously and made it clear he found the whole thing irritating. He had not made any effort to update his skills and knowledge through CPD. There was no prohibition on attending CPD events because of his suspension (as he had suggested in a letter of 19 March 2010 – see p. 100) and even if he had found some embarrassment at attending events where local colleagues would know him to be suspended, a normal concerned GP would have had an audit trail of CPD electronic events in which he had participated.
43. Dr Barker pointed out that page 99 showed a review of the records of all 15 patients who had died between 1 April 2008 and 31 March 2009 disclosed no evidence that poor clinical management by Dr Alijah had caused the deaths. Nor was any evidence found of avoidable emergency hospital admission on a random sample of 60 emergency admissions over the same period.
44. Dr Barker was however concerned to make clear that there were very real patient safety issues, and referred to page 90 which showed the magnitude of the problem: if the findings demonstrated by the two random case note reviews were applied to a typical calendar month's consultations (650 per month) then there would be 50 causes for concern, 80 inadequate histories, and 80 inadequate physical examinations each month.
45. We asked Dr Barker whether he had evidence of other patient contacts apart from the ones referred to at page 98 but he did not. He said that the prescriptions asked for by Dr Alijah were in fact issued by Dr Haider to the patient whose house Dr Alijah visited. It was not repeat medication so an assessment of the patient would have had to be made by him. Nor was it an emergency (such as might arise in an otherwise social setting). Dr Alijah simply did not take seriously the condition to abstain from clinical contacts.
46. He told us that Coventry Local Medical Committee was involved in this as in other cases from the outset and to the best of his knowledge a representative was in touch with Dr Alijah in May and December 2009.

47. In terms of efficiency Dr Barker's main worry was the issues around Dr Alijah's clinical performance. In terms of suitability it was the absence of insight into his shortcomings. But it was looking at all those things together as described in his report.
48. Dr Barker said that for him the most serious case was Patient C, a 56 year old male where Dr Alijah's working diagnosis was Urinary Tract Infection (UTI). Dr Alijah made an elective referral to the Consultant Nephrologist 6 days after seeing the patient, but was aware, or should have been aware, of the very raised CRP count and raised ESR indicating an inflammatory process. The patient ultimately underwent an emergency cholecystectomy which carries a 50% mortality rate and was therefore put grossly at risk by the missed opportunity for urgent referral. Moreover Dr Alijah's response to questions about his follow-up for this patient ("I know about [his] behaviour. He would simply disappear and not come back") was unacceptable because it was judgemental about the patient and denied him correct follow-up.
49. In addition he was particularly concerned about cases A and B, both of which concerned the management of chest pain. Dr Alijah practised in a South Asian patient population which was 1.6 – 2 times more at risk than a white British population, so it was particularly risky not to be able to deal adequately with cases of chest pain.
50. We questioned Dr Barker further about the audits. He said the dates and sessions were chosen at random, and all patients for those sessions were reviewed, so the findings were indicative of the underlying range of problems. This method had been used by him before and was well established. There was no "gold standard" or benchmark of what he expected to find, but he and the auditors were aware of the tolerance levels around what a normal peer group of competent practitioners would find acceptable. He had had NCAS training. He had done about 10 of this kind of investigation and Dr Alijah's performance was very poor compared to the others he had done.
51. When Dr Barker received Dr Alijah's letter of 19 March 2010 (p 100) he was very surprised by the suggestions that Dr Alijah was restricted from undertaking CPD, and had limited himself to reading medical journals. He therefore spoke to Chris Taggart who organised the PCT's appraisal system, but he did not think there was any formal attempt to produce a programme for Dr Alijah. Formal Postgraduate training sessions were conducted weekly on a Wednesday lunchtime and there were monthly protected learning times which were circulated to all GPs by email and letter. At appraisal a doctor (including Dr Alijah) should have a Professional Development Plan (PDP) and be able to say how they had achieved the objectives in the preceding year. Dr Alijah would have been able to speak to Dr Paul Chohan his appraiser and Dr Taggart who was in charge of appraisals generally. He was concerned about his last appraisal being in December 2008. Dr Barker thought Dr Alijah's updating and appraisal of his skills was not fit for the purpose.
52. Dr Robert Jones gave sworn testimony, and confirmed the accuracy of his statement [p 30 et seq] and report [p 36 et seq]. He has been a full time GP principal since 1990 and a trainer for 5-7 years. He had reviewed records of surgery sessions conducted by Dr Alijah on dates within a range of months given to him by Dr Barker. He had selected dates that were typical surgeries but otherwise random selections, namely 6 January and 20 March 2009. He had also looked at records from 18 March 2009.

53. Dr Jones referred to his report (entitled “assessment of Clinical Records 28/5/10) at pages 36 - 39 of the hearing bundle. 15 patient records were considered (although it was not clear whether one of those patients had in fact been seen) from 20 March 2009 of which he considered 12 disclosed poor practice such as no examination recorded, no or poor history taken, or poor treatment offered. Another 15 patient records were examined from 6 January 2009, of which 7 disclosed no concerns and 8 revealed similar poor practice. On 18 March 2009 11 patient records were created (although 18 patients were booked to attend), and examination of the records showed deficiencies in 5 cases.
54. Dr Jones observed that in those cases where no examination was recorded, it was not possible for any other doctor (such as a locum) who next saw the patient to get a feel for how ill the patient was previously or what was the working diagnosis. If the patient returns you have no idea if the positive findings you observe were there previously. Patient safety implications could be great. The severity of the condition may depend on how long it has been going on and the way it is progressing. With Dr Alijah’s notes the next practitioner would be starting off afresh.
55. He explained his conclusions in a number of the individual cases summarised at page 36:
    1. Case 3847. Reynaud’s was a connective tissue disorder presenting with cold hands. It was not necessarily wrong to prescribe Nifedipine but it was a treatment of last resort, and the patient should be advised to keep warm. Overprescribing depended on the case and any drug could have side-effects.
    2. 1009. A 2 year old child’s “flu-like” illness was treated with Amoxicillin but no examination was recorded. A child with viral symptoms was likely to be feeling unwell and Amoxicillin will not treat viruses and can cause side-effects. It could be justified if there was bacterial infection but there was no examination to justify the prescription given.
    3. 2405 was treated with Co-Amoxyclav, a strong antibiotic for which there was no indication, and can cause symptoms such as diarrhoea. . The recorded diagnosis of acute nasopharyngitis is essentially the common cold and was no indication for antibiotics.
    4. 6040. Dr Jones said that 6 months was a long time to have abdominal pain, and the tablets prescribed would only treat the symptoms. There was no examination or working diagnosis or a management plan to follow up the patient. For example a competent history would be looking at features of the pain, such as whether it was constant or spasmodic: abdominal pain is very vague. An attempt should be made to narrow it down to a system such as the bowels or urinary tract. The records did not give any information as to whether the patient had visited the GP over the previous 6 months, nor was there a history.
    5. 4744. Again, an antibiotic was (wrongly) prescribed for the common cold.
    6. 9606. Orciprenaline is a linctus which was prescribed 20 years ago for babies who were wheezy. It is not now generally used and does not appear in any pharmacology guide. It was not found to be effective, but Dr Jones was not aware of any patient safety implications.

7. 2744. This case indicated lack of familiarity with the IT system, which itself had been in use since before 1994. Dr Alijah said he had been operating it for 10 years. But there was no 10 year risk assessment for coronary heart disease (CHD) despite the patient having dyslipidaemia. In primary medicine GPs tried to tailor the treatment to the 10 year risk status of the patient, which the computer system would do for you. The issue was whether it was appropriate to be giving simvastatin: the risk was of over-treating, although Dr Jones conceded this was a safe drug so there was no real risk of harm to the patient.
8. 8288. There was no justification for prescribing antibiotics in this case.
9. 3100 was another case with no recorded history, examination or clinical reasoning. Solar keratosis (small skin lesions caused by the sun) can be pre-cancerous. Dr Alijah had noted that she had "intermittent claudication" but she did not.

56. Dr Jones commented further on some of the cases reviewed from the 6 January 2009 surgery (page 37):
    1. 8864 concerned a presentation by a 25 year old male heroin addict for a corn under the metatarsal head which was treated appropriately but in passing Dr Jones had noted the patient had also attended on 30 January 2009, and prescribed 60 tablets of Temazapam for "insomnia for one month". Temazapam is addictive and can be abused. Normally it would not be prescribed as a first line of treatment for poor sleep. The dose is one or two tablets at night, so 60 tablets was a lot to prescribe, particularly where the patient was a heroin addict, as you would have to trust the patient with this quantity. He had been sufficiently concerned to have made a footnote to his report although it fell outside the patient management he was looking at on 6 January 2009.
    2. 5520. Temporal arteritis is inflammation of the temporal artery and is a serious condition which needs to be treated as an emergency. The symptoms described required that condition to be considered. Dr Jones was careful to say he did not know if Dr Alijah had done so, but he had made no note.
    3. 721. This case again showed the lack of recorded history and findings to enable a doctor to discriminate whether the complaint of "ectopic heartbeats" was a palpitation of no significance or something more concerning. There was no information as to how long this had been going on and how troublesome it was.
    4. 1595. This case was one of three which gave Dr Jones cause for serious concern (see page 31, paragraphs 8 – 11 of Dr Jones' witness statement and p 39). "Pleuritic pain" is not a diagnosis but a description of a symptom (pain on breathing). Duodenal ulcers can recur and give pleuritic pain. This patient had a duodenal ulcer in 1979. Pleurisy is another possibility. There was no indication as to what the likely diagnosis was, and no evidence the patient was examined, or a proper history taken including how unwell he was. Moreover it was not possible to identify the justification for the diagnosis of pharyngitis. It was treated with antibiotics, which are only effective against bacteria, but pharyngitis is rarely bacterial, and if it is, there is usually pus observable at the back of the throat. This finding would have been unusual enough to be recorded, if an examination had been made.

Normally, however, there is simply a red appearance at the back of the throat and this is viral infection.

5. 8923. This case was another of the three cases causing Dr Jones serious concern. The patient was a 4 year old girl and Dr Jones referred to paragraph 13 of his statement. “Dehydration” is a clinical diagnosis made from the history and examination, which was not possible here because there was no record of an examination and very little history. Instead Dr Alijah had requested a blood test to assess urea and electrolyte levels (“U & E”). The essential thing is to assess the child’s hydration. By the time the mother took her to hospital, got a blood test taken and processed and the results were returned some hours later, the hydration levels of a 4 year old were likely to have changed very quickly. Dr Jones could not think of a circumstance which would justify giving this child a blood test. Indeed shortly after this event NICE had published guidance that reflected existing awareness of good practice among GPs, and Dr Alijah should have been aware of those standards.

57. Turning to the patient records summarised on page 38 of the bundle Dr Jones highlighted patient 2365, another patient whose treatment gave rise to grave concerns. In April 2008 another doctor had done a very careful and full examination and created a good clinical note, which provided a valuable comparison with Dr Alijah’s notes. When this patient presented to Dr Alijah on 18 March 2009 with “pleuritic pain”, he did not record any examination and the history does not reveal the duration of the pain, nor is there any follow-up plan noted. Dr Jones conceded that if Dr Alijah had in mind the factors he subsequently mentioned and set out at paragraph 12 of Dr Jones’ statement (p 34), this case was not as serious as the concerns identified in cases 1595 and 8923.
58. In those cases where antibiotics were prescribed for viral illness, to no therapeutic purpose, Dr Jones acknowledged (in answer to the Tribunal) that patients from the cultural background of Dr Alijah’s patients might well have a lower threshold for consulting him and would be more likely to want a prescription of antibiotics, but proper clinical practice should not change for different populations. He would expect that some effort at patient education be made, to inform them how a viral illness should be managed. Failure to have this conversation with the patients created a cost to the public purse and antibiotic resistance.
59. Dr Jones said that this standard of record keeping was below the level which would be acceptable to his competent peers. In answer to further questions from the Tribunal he said that the quality of care delivered on the days examined, judged from what was recorded, was 1 or 2 on a scale of 1 to 10. There was also evidence of poor clinical practice. Lack of examination findings was indicative of a poor level of clinical performance.
60. Dr Barker was briefly recalled because of his knowledge of the drug Orciprenaline, prescribed in the case of the 2 year old patient 9696. He said it was an adrenalin type of drug which would open up the airway to prevent wheezing, but if the problem was caused by asthma it does not treat the underlying inflammation. Its use is not evidence based, and Dr Barker was extremely surprised to see it prescribed by Dr Alijah. It was available for

prescribing in the UK but was not used nowadays. Many combined adrenaline products were removed from the market in the early 1980's

Submissions

61. Among other things, Mr Gray submitted that Dr Alijah should be removed from the Performers List on grounds of efficiency and suitability and should be nationally disqualified.
62. In relation to suitability he relied on five aspects of his behaviour and conduct:
    1. Lateness and general behaviour;
    2. His attitude to CPD while suspended;
    3. Seeing patients while he was suspended;
    4. The clinical audits;
    5. His lack of insight.

    The last of these could be said to run through them all.
63. As to the first of these, he drew out attention to page 104 of the bundle, and submitted his conduct was inconsiderate to patients and colleagues and put patients at possible risk. The GMC's "Good Medical Practice" [relevant parts of which were copied at tab 31 of the hearing bundle] made plain that a doctor must make care of his patients his first concern, but this doctor had shown no regard for his patients.
64. The non-attendance evidenced at page 106 could not be excused, and was unprofessional. He was attending very late most days. If he was suffering some stress-related illness then he should have notified the PCT and seen his GP to get a certificate and treatment and give his colleagues to arrange cover. He was self-evidently capable of getting to work because he did so, albeit very late.
65. Dr Barker's evidence demonstrated the fairness with which the investigation was conducted, acknowledging as he did the tricky position Dr Alijah may have felt himself to be in attending local training events. But Dr Alijah's attitude to CPD was demonstrated by his letter at page 100.
66. Mr Gray contrasted Dr Alijah's unwillingness to discharge his professional obligations to his patients generally with his willingness to enter the practice to get a prescription for a patient who was a friend. He placed reliance on the fact that Dr Alijah was seeing a patient while suspended for the purpose of showing lack of insight and of unsuitability. He observed that it put his staff in a difficult position. He referred to the letter from 4 staff at page 98 and said that this was not the only time Dr Alijah had done it. The reason for the restriction on attending his premises was to avoid this very situation where staff were subject to outbursts.
67. However he placed heavy reliance on the clinical audits and revisited a number of the individual cases and summarised the proportion of cases where some deficiency had been found. He said the scale of these deficiencies was unacceptable, and reminded us of Dr Jones' "score" of 1 or 2 out of 10. He stressed the case was not just about poor record keeping but what the record keeping revealed. One obvious example was the overprescribing of antibiotics with potential impact on the public purse and the risk of increased resistance of organisms to antibiotics, both as a matter of public health and for the individual patient.
68. He also reminded us of the 6 cases of concern referred by Dr Haider and the responses made by Dr Alijah when questioned about them. Where there was overwhelming evidence of underperformance as there was here, he

suggested we should expect to see acknowledgement by the doctor of shortcomings. In fact the nature of his responses and behaviour demonstrated gross lack of insight and failure to engage with staff concerns.

69. Mr Gray also invited us to take account of Dr Alijah's failure to engage with this appeal process either by communicating with the PCT or complying with any orders of the Tribunal, and his conduct in seeking an unjustified and unsupported adjournment, as evidence of his continuing lack of engagement and unwillingness to acknowledge fault.
70. If we considered that unsuitability was not proved, Mr Gray invited us to say this was not a proper case for contingent removal. Nothing was more likely to affect efficiency than his behaviour in late 2009.
71. He also reminded us of the application for National Disqualification and submitted that if we found that Dr Alijah should be removed from the List on either basis, then we should conclude that these shortcomings would be repeated in any new area where he was admitted to a Performers List.

Consideration and findings

72. The Tribunal was impressed with the two PCT witnesses from whom we heard. Both were careful, deliberated their answers to questions in a measured way, and were willing to make concessions where appropriate or to acknowledge the day-to-day practical difficulties and pressures for a GP. We are entirely satisfied that the investigation conducted by Dr Barker was fair and, where possible, focused on aspects such as the audits where objective criteria could be applied. We accept their evidence.
73. We have also taken into account the other documentary evidence which we have seen (subject to excluding page 109). Dr Barrett conducted a further independent audit exercise of patient records generated during surgeries on three further random dates (23 and 28 September and 1 October 2009). He has made a witness statement [42-47] about them, signed under a statement of truth. The methodology is similar to the audit conducted by Dr Jones, and the findings both objective and consistent with those emerging from Dr Jones' audit. We find it persuasive and accept the thrust of the findings and criticisms emerging from this audit also.
74. We note that among the cases of concern identified by Dr Barrett was Case reference 693, a patient on the Coronary Heart Disease Register who was being treated for "Dyspepsia" without any record of a history or examination, and Case reference 4626, a patient with rectal bleeding who was not examined, nor any history taken. In the former case there is an inference of lack of computer skills in bringing up the code which would reveal CHD. Both these patients were recalled for examination by Dr Haider because of concern during the course of the investigation.
75. We find the methodology adopted by both audits to be fair and reasonable. Taken together, the independently conducted elements of the investigation tend to support each other. The audits also identified good or acceptable practice where it was found.
76. In our judgement the record keeping of Dr Alijah was grossly deficient. We accept it was pretty near the bottom end of the scale of record keeping, even if we are inclined to think that the score of "1 or 2 out of 10" given by Dr Jones was a little too harsh, making allowance, as we do, for the possibility that an experienced clinician who knows his patient population well may make briefer notes. But we accept that good record keeping is important for the reasons

given by Dr Jones at paragraph 54 above and which indeed is underlined by the requirements of the GMC in its publication “Good Medical Practice” at paragraph 3 (f) [p. 122].

77. Indeed we are satisfied that (even taking into account the limited responses provided by Dr Alijah in the course of his interview on 7 July 2010, or on his behalf at the Oral Panel Hearing on 27 September 2010) in those cases where Drs Jones and Barrett found no recorded examination of the patient or history taken or follow-up management plan recorded, it is unlikely that Dr Alijah did adequately perform any of these necessary tasks at all.
78. We find that these deficiencies give rise to inadequate patient care and an inevitable risk to patient welfare.
79. Dr Jones and Dr Barrett identified 6 cases in the course of their separate audits which gave rise to serious concerns in their opinions, supported by Dr Barker. We accept that this is the case, with the caveat conceded by Dr Jones about Case 2365 (see paragraph 57 above). In addition, we were concerned to note that in case 5057 a 39 year old woman was prescribed Orlistat (a drug designed to manage weight gain by preventing the absorption of fats from the diet) with no baseline weight recorded, no evidence of lifestyle counselling, or discussion about the side-effects of this drug. These cases emerge from a mere 5 surgery sessions conducted by Dr Alijah.
80. The specific concerns raised by Dr Haider include several which in our view are quite serious. We accept Dr Barker’s summary of the mischief in each case which is conveniently set out at page 96 of the hearing bundle.
81. We accept that Case C (see page 93) is particularly serious because of the implications for patient safety, for the reasons set out at paragraph 48 above. In our judgement it is unacceptable not to pick up and respond urgently to the high levels of CRP and white cell count. This patient’s life was put at risk by a failure to arrange an urgent hospital referral.
82. Dr Alijah’s response to Case C on 7 July 2010 (page 93) is also revealing and of great concern. There is no hint of insight into his own shortcomings or the risk created for his patient. Instead he adopted a judgemental approach, effectively blaming the patient for his own failure to arrange follow-up, by suggesting “I know about his behaviour. He would simply disappear and not come back”. We noted that in fact this patient was sufficiently concerned for his own welfare to self-refer to hospital, when an emergency cholecystectomy was performed.
83. We also accept that Cases A (page 92) and D (page 94) show major deficiencies and give rise to serious concerns about clinical management skills. In the former case an episode of chest pain was treated with glycerol trinitrate (GTN) and no arrangements for follow up or referral were made. There was no further presentation until February 2010 when the patient was referred to a Rapid Access Chest Pain Clinic by a locum (Dr Khan). The RACPC letter dated 22 March 2010 describes atypical chest pain and “angina unlikely but would be better to establish history more thoroughly”. In interview he said he had told the patient to ring if she got relief or not. We accept that because Dr Alijah had recorded no management plan, no follow-up arrangements were made. This South Asian lady was in an at risk group for coronary heart disease. It is likely that referral to a RACPC was delayed.
84. Case D concerned a 65 year old man with a history of unstable angina and a coronary artery bypass graft. He was seen by Dr Alijah on 12 May 2008

complaining of angina on effort for one month. No examination was documented, and no referral or follow up arrangements were made. The patient subsequently re-presented on 15 September 2008 with recurrent angina and was referred to the RACPC, which made changes to his medication. When asked about this Dr Alijah appears to have blustered. He first said he must have referred the patient (but he had not) then that the patient must have had an appointment with the Consultant (he did not) then that the patient was an educated man, who might have had an angiogram abroad in India but could not recall the details. None of this was noted. He did concede that on a future occasion he would refer the patient. We are satisfied that the delay in referring this patient was unacceptable and put the patient at risk.

85. Those cases of particular concern are against a background in which between 50% and 80% (varying between particular dates) of the case records of patients reviewed at the two random audits were substandard, as we find. Translated to a normal caseload for Dr Alijah in a calendar month, this would give rise to 50 causes for concern, 80 inadequate histories, and 80 inadequate physical examinations each month. We have no reason to suppose that the findings from the several audit dates were uncharacteristic, and it follows that we accept that this would be the rough effect of Dr Alijah's approach to patient care, over a calendar month.
86. We further find that on numerous occasions, exemplified by the cases described above, Dr Alijah failed to formulate or to record a proper follow-up or management plan for patients who needed to be monitored to exclude or confirm serious illness. We accept the findings of the audits on this respect too.
87. We are also satisfied that the audit demonstrates Dr Alijah's lack of facility with the computerised patient record system which he has operated for about 10 years in his GP Practice. For example he tends to record multiple problems raised by a patient as separate consultations. This is not in itself a major flaw but the computer system has features which represent a potentially valuable tool for a GP to identify patients at underlying risk and patients have a right to expect that they will have access to those benefits.
88. The cases of concern identified and set out in our hearing bundle arose over a period examined from April 2008 to November 2009. We have no evidence from earlier periods. However, we asked ourselves whether the deficiencies might have been explained (if not excused) by events which were said to have caused Dr Alijah stress or distracted him within the practice. We note that a number of the cases pre-date any period when we have evidence of such stress. We also note that neither in interview, nor in the course of the Oral Hearing before the PCT Panel, did Dr Alijah suggest that this or any other exceptional reason explained the alleged deficiencies in patient management. Nor has he put in evidence of his own in this appeal from which we could properly infer such a case.
89. The responses given by Dr Alijah throughout the interview on 7 July 2010 are inadequate and demonstrate a lack of insight and self-awareness. He had had plenty of opportunity to consider how he might respond because he had the papers relating to his management of these patients almost two months earlier, and was supported by a medico-legal adviser at that meeting.

90. Dr Alijah's persistent and significant lateness for booked surgeries and indeed failure to attend at all on two occasions prior to his suspension, has not in our view been adequately explained or even remotely excused by Dr Alijah. He does not claim he could not work, as he did in fact turn up (albeit late) on most occasions; on the contrary he said he was in good health and two subsequent psychiatric examinations and an occupational health assessment support that. He has said that the atmosphere with staff had deteriorated following an earlier (unconnected) suspension. We cannot accept that this is a reason not to attend booked clinics, still less to give no notice and therefore prevent arrangements for a locum being made.
91. The lateness and non-attendance is compounded by Dr Alijah being uncontactable (or not readily contactable) by his practice staff. This is also a requirement of the GMC's "Good Medical Practice" (see page 122 item 3 (h)).
92. We note the explanation given by Dr Alijah for not attending surgery, when asked about it on 7 July 2010 (see foot of page 9): "A big disaster … both phones failed …. My wife was not with me that day …. The staff were not helpful …. The staff did not firing anyone to find me …. Me dozing off". Even allowing for the summary nature of this note, it is an astonishing response, which invites us to accept the unlikely failure of two telephones (notwithstanding the evidence of his practice manager that the staff did not have a landline number to call) and that the ability to contact him depended to some extent on the accident of whether his wife was with him, and that staff had made no effort to contact him (despite the evidence to the contrary in the hearing bundle) and that it was somehow the fault of staff that he was not contacted, and that dozing off might excuse a failure to attend a booked clinic. In our view it demonstrates a deep-rooted lack of insight, an inability to accept shortcomings and a willingness to blame others for those shortcomings.
93. We have also considered the evidence of his reply to his Practice Manager Yasmin Kouser (see paragraph 34 above) when she asked him about his failure to respond to phone messages: "I am 70 years of age, and it is mean of you to ask me to work!" [see p 107]. Dr Alijah has neither admitted nor denied this, or any other parts of the documentary evidence. Sadly, we are driven to conclude that it is more likely than not to be correct, and is consistent with Dr Alijah's conduct in turning up (or not turning up) when he liked, and with the self-justifying but unacceptable explanation given to Dr Barker.
94. We find this conduct to be unprofessional, both to his patients and colleagues, and self-evidently gives rise to inefficiency in the services offered to NHS patients. In the respects outlined above Dr Alijah was also placing his own convenience above the interests of his patients.
95. On the evidence we have considered, Dr Alijah has not undertaken any adequate Continuing Professional Development since early 2009, despite being in contact with his appraiser and with the doctor who oversees appraisals for the PCT (see paragraph 51 above). On the face of his own letter written on 19 March 2010 (see page100) his CPD has been limited to reading such medical periodicals as he could get his hands on. We note that Dr Barker acknowledged that he might have felt a difficulty in accessing the full range of locally available training sessions because of potential embarrassment with local colleagues. However information about sessions was sent to all doctors on the List and in any event Dr Alijah had taken no

steps to update his clinical skills via electronic learning (now widely and easily used) or private lectures or seminars. The overriding concern is to ensure that a practitioner maintains and updates his skills in the interests of good patient care, rather than hides away because he is suspended.

96. We are satisfied that Dr Alijah did have inappropriate contact with the patient identified at page 98 of the hearing bundle during the period of his suspension and that that was not excusable as being an emergency with which Dr Alijah was confronted while having normal social contact with an individual with whom he was on friendly terms. It was not repeat medication so an assessment of the patient would have had to be made by him. He badgered staff to get a prescription issued for the drug he wished the patient to have, and even visited the surgery to follow it up. We are satisfied that Dr Alijah had received a letter of suspension and an explanation from Dr Barker as a result of which he knew, or should have known, that he was not to do either of these things during his suspension, but he appears to have paid little regard to that. Sadly, this is part of a general picture of lack of insight, and lack of proper engagement with the PCT and the disciplinary process.
97. We were invited by Mr Gray to have regard to Dr Alijah's complete failure of co-operation with the Tribunal or the PCT during this appeal process as part of the picture of failure to engage. We have not felt it appropriate to do so. But that does not mean we ignore what he has done or has failed to do to remedy his professional deficiencies since September 2010: no evidence has been put before us of any remedial steps taken by Dr Alijah, to improve his skills in the areas identified as defective, such as retraining in specific areas, CPD activity, engagement with a mentor or assessor, or preparation of a Personal Development Plan.
98. The PCT has sought to look at the evidence separately under the headings of efficiency and suitability. We do not think it is necessary or practicable in this sort of case to say that particular evidence falls to be considered *exclusively* under one or other of those headings. There is in practice considerable overlap. Some matters, such as persistent inappropriate prescribing of antibiotics or failing to attend surgeries so that patients leave without being seen, or a colleague has to "double up" his own surgery session, clearly lead to waste of resources and are prejudicial to the efficiency of the services those on the Performers List perform. Likewise the failure to make a note of the patient's history and examination findings so that a subsequent doctor has to start afresh to monitor the progress of a patient's condition. But they also have, or may have, an adverse effect upon patient welfare or safety, albeit less obviously or directly than clinical errors of treatment or management of the kind exemplified by the 6 cases of particular concern identified in the two audits, or the 6 cases about which Dr Alijah was questioned on 7 July 2010.
99. Unsuitability is not defined in the Regulations, no doubt because of the many ways in which it might in practice arise. Among other ways, it may arise from persistent uncorrected, or uncorrectable deficiencies which, on a limited or "one-off" basis, may simply amount to an inefficiency case, or it may arise from serious and widespread professional deficiencies, misconduct or character traits which undermine the provision of medical services and patient welfare.

Conclusion

100. We have concluded that the case is made out against Dr Alijah under Regulation 10 (4) (a) ("efficiency") and 10 (4) (c) ("suitability"). The cumulative effect of our findings is to demonstrate a 70 year old practitioner who, whatever his years of service to patients in the past, has become disengaged from the needs and priorities of GP practice. The range of his deficiencies in clinical care and management is large, embracing record keeping, history taking, examination of patients, follow-up arrangements, knowledge of modern prescribing, unjustified prescribing, lack of attempts at patient education and lack of facility in operating the computer software system. Some or all of these deficiencies have thrown up cases where patient welfare was put at risk in the ways described by Dr Barker, Dr Jones and Dr Barrett. It is not just the odd case, but a significant number cases in the snapshots provided by the audits we have seen and the cases of concern referred by Dr Haider.

101. Moreover, we are satisfied that his behaviour during late 2009 in missing or being late for booked surgeries betrays an unacceptable attitude to his responsibility to patients and (secondarily) to his colleagues. We are also satisfied that his responses to the criticisms of his clinical practice in particular in the interview on 7 July 2010, demonstrate lack of any real insight into his deficiencies or awareness of what he should do to put them right. The response to Ms Kouser when challenged about not responding to messages reinforces this conclusion. He has been cavalier in observing the restrictions on seeing patients or visiting the surgery which arose from his suspension.

102. We have concluded that Dr Alijah has by his conduct and (when he has chosen to say anything) by his words, demonstrated that his lack of insight is deeply entrenched, unimproved, and probably irremediable. We see no sign of the necessary degree of awareness of his deficiencies, or of the steps he needs to take to remedy them, still less any resolve to do so. We are therefore driven to the conclusion that he is unsuitable to remain on the Performers List.

103. If we were wrong about suitability and it was necessary to consider this simply as a case of efficiency the question of a contingent removal would arise. But for the reasons given above we do not consider that Dr Alijah would be willing to address his deficiencies or co-operate in devising and implementing an effective programme of remedial learning, even if conditions could be formulated which addressed the wide range of deficiencies. We therefore conclude that even if we were to deal with this case as one of efficiency, we would direct removal from the Performers List.

National Disqualification

104. We have considered National Disqualification, as the PCT invited us to do (having given appropriate notice at the beginning of this appeal process). There is no statutory guidance on the factors to be applied in considering National Disqualification. It is available whether the ground for removal is a mandatory or discretionary one, and if discretionary, whether it is on grounds of suitability, fraud, or efficiency. In our view these wide powers are conferred on us so that we can deal with the multiplicity of different factual situations which arise without the necessity to pay undue regard to the label attached to the conduct or deficiency.

105. The "Advice for Primary Trusts on Lists Management" published by the Department of Health in 2004 says at paragraph 40.4 that a PCT should "*recognise the benefits of a national disqualification both for protecting the*

interests of patients and for saving the NHS resources". It says further that *"this additional sanction is necessary in the most serious cases, only when a doctor has been ….removed by a PCT from its own list, and it is imposed by the FHSAA"* and *"unless the grounds for removal … were essentially local, it would be normal to give serious consideration to such an application"*.

106. The principles derived from published Guidance and from cases determined by the FHSAA to date establish, in our view, that:

a. Serious consideration should be given to national disqualification where the findings against the practitioner are themselves serious and are not by their nature essentially local to the area where the practitioner was working;
b. Other relevant factors are:
    i. The range of the deficiencies or misconduct identified;
    ii. The explanations offered by the practitioner;
    iii. The likelihood of those deficiencies or conduct being remedied in the near to medium term;
    iv. Patient welfare and the efficient use of NHS resources;

    but balancing those against -

    v. The proper interests of the practitioner in preserving the opportunity to work within the NHS (which includes both pursuing his professional interests and earning money).
    vi. Whether national disqualification is proportional to the mischief of the Panel's findings as to the conduct or clinical failings of the practitioner, and to consider the common law requirement that national disqualification is reasonable and fair (see *Kataria v Essex SHA* [2004] 3 AER 572 QBD).
c. The standard of proof which we should apply (where fact-finding is involved) is the balance of probabilities, in accordance with the guidance of the House of Lords in *Re D* [2008] UKHL 33. .

107. We refer to our findings from paragraph 66 onwards, above, and to our conclusions on the issues of suitability and efficiency on both of which grounds we found Dr Alijah should be removed from the Performers' List.

108. These adverse findings are not limited to the locality in which Dr Alijah has practised. Some instances of poor practices pre-date the arrival of Dr Haider in the practice (with whom Dr Alijah has not remained on good terms). The range of deficiencies and their seriousness (whether actual or potential) covers a wide range of necessary skills. His explanations do not raise excuses and in fact demonstrate lack of insight. There is no realistic prospect of their being remedied in the near to medium future. Patient welfare would be put at risk and the efficient use of NHS resources would be likely to be affected if he were to be on a Performers List.

109. We therefore conclude and direct that Dr Alijah should be nationally disqualified for a period of 2 years commencing with the date of this Order, and that the individuals and bodies identified in paragraph 4 (iii) above be informed.

Duncan Pratt
Tribunal Judge 15 April 2011