Case Number 13329

IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

On an application for National Disqualification
Hearing: 20th November 2006

Panel
Mr D Pratt (Chair)
Dr S Ariyanayagam (Professional Member)
Mr M Cann (Member)

BEETWEEN:

SOUTHAMPTON CITY PRIMARY CARE TRUST

Applicant

-and-

DR WOLFGANG SCHNEIDER (GMC No. 6087288)

Respondent

DECISION AND REASONS

1. This is an application by Southampton City Primary Care Trust ["the PCT"] for National Disqualification of Dr Wolfgang Schneider ["Dr Schneider"] under the provisions of Regulation 18A of the National Health Service (Performers' Lists) Regulations 2004 as amended ["the Performers Regulations"], and Section 49N of the National Health Act 1977 as amended, from all the lists referred to under that Regulations 18A; in substance, disqualification from all National Health Service Performers' Lists or supplementary lists.

DECISION

2. Our unanimous decision is that Dr Wolfgang Schneider (GMC Registration Number 6087288) shall be disqualified from inclusion in the following lists mentioned in Regulation 18A of the Performers Regulations, namely a Performer's List, a list referred to in section 49(N) 1 of the 1977 Act prepared by a Primary Care Trust, and any supplementary list prepared by a Primary Care Trust.

REASONS

Background and Preliminary Matters

3. This PCT had previously removed Dr Schneider from its own Performers List under Regulations 10 (3) and (4) of the NHS Performers List Regulations 2004. The removal was on the ground that Dr Schneider's continued inclusion in the List would be prejudicial to the efficiency of the services which those in included in the List perform (an "efficiency" removal). There was no appeal against its decision, which was sent by a letter, dated 14 July 2006 and was apparently received by Dr Schneider on 20 July; on that date he signed a recorded delivery at his normal address in Germany. By Regulation 5 of the Family Health Services

Appeal Authority (Procedure) Rules 2001 ["the Rules"] Dr Schneider had 28 days in which to appeal the decision. He did not do so, either within that time limit or at all.

4. The PCT has agreed, in writing, that we should determine this application on the papers, without an oral hearing. Dr Schneider has not responded, whether to the notification of this application sent to his usual address on 22 September 2006, or to any further correspondence, including an invitation to agree to the application being determined on the papers. We are satisfied that the correspondence, including notification of this application by the PCT and of the hearing date, has been sent to the correct address at which he was probably residing. In reaching this view we have taken into account that:
    a. the address to which the FHSAA has sent correspondence is the same address at which Dr Schneider received, and signed for the removal decision of the PCT on 20 July 2006;
    b. He wrote to the PCT from that address on 4 July 2006 with representations about the preliminary findings of its Screening Panel;
    c. The correspondence has not been returned to the FHSAA.
5. Since Dr Schneider has not replied within the time limited for doing so by Rule 23 (21 days), or at all, we are empowered by the terms of Rule 38(2) to determine the application on the basis of the documents provided by the PCT. The Panel decided to proceed on that basis. Nevertheless this hearing had been fixed by the administration unit of the FHSAA. Dr Schneider had the opportunity to attend and say whatever he wished. We did not adjourn until after 1.15 pm on the date of the hearing, but Dr Schneider did not attend.
6. We are satisfied this application by the PCT was made within the time limit of 3 months beginning with the date of the doctor's removal from the list as provided by Section 49N (5) of NHS Act 1977 as amended.
7. The evidence seen by this Panel was:
    a. the PCT's letter of application dated 23 August 2006 and supporting bundle of documents paginated 1 to 52, together with
    b. the FHSAA's letter of 29 September 2006 to Dr Schneider, enclosing the notice of the application, and
    c. a further letter from the PCT, dated 6 October 2006, agreeing to the case being determined on the papers.
8. We have evaluated for ourselves the evidence relied upon by the PCT in reaching its conclusion to remove Dr Schneider from its list, but in the absence of any challenge or rebutting evidence from Dr Schneider have given due weight to the findings of the PCT. We reminded ourselves that the standard of proof to be applied is that we must be satisfied of any particular fact or allegation on the balance of probabilities, recognising also that where allegations are serious, cogent and compelling evidence is required if they are to be found

proved. When considering whether we are satisfied on a balance of probabilities that an allegation is established we bear in mind that the more serious the allegation, the less likely it is that it occurred and the stronger should be the evidence before we conclude that the allegation is established.

9. Dr Schneider was born on 25 May 1938, and is therefore aged 68. He previously had his own practice in Internal Medicine in Germany for some 27 years, before selling it to a colleague and continuing to do the equivalent of locum sessions for about 8 hours per week. According to a letter he wrote to the PCT on 4 July 2006 he started to perform Out of Hours ["OOH"] weekend services in England in September 2004 and did about 25 weekends between then and December 2005.
10. The PCT received three written complaints about Dr Schneider, arising from OOH attendances on three elderly female patients:
    a. Sunday 23 October 2005 - Mrs JH, who suffered terminal bladder cancer;
    b. 20 November 2005 – Mrs PP, who had a urinary tract infection;
    c. 17 December 2005 – Mrs NW who suffered undiagnosed fractures of the tibia in both legs.

    In each case the written complaint was made by the adult child of the elderly patient, in the latter case supported in writing by the patient's local authority carer.
11. The PCT considered these complaints, supplemented by information provided by its Clinical Governance Lead Dr A Kadri, based on his investigations, including a telephone interview with Dr Schneider. This method of contact was necessitated by the fact that Dr Schneider was not doing OOH sessions for the agency formerly employing him until the complaints were resolved, and was therefore not in the UK.
12. This material was considered first by a screening panel, whose conclusions were sent to Dr Schneider. He responded by a letter dated 4 July 2006. All this was then considered by a different Panel appointed by the PCT. Its decision was to remove him from the List.

<u>The basis of the application</u>

13. The reasons given by the PCT for its decision to remove Dr Schneider from their list (and relied upon again for this application) were:
    a. Unsatisfactory assessment of patients
    b. Poor communication
    c. Lack of insight into the care needed for elderly patients
    d. Failure to prescribe adequate analgesia
    e. Inappropriate action taken
    f. Notes do not demonstrate a full assessment.

Three consultations with elderly patients were considered.

<u>(1) Mrs JH</u>

14. The first was on 3 November 2005, with Mrs JH, who was terminally ill, suffering bladder cancer. Her daughter and son-in-law were also in attendance and were the complainants. It was said that:
    a. Dr Schneider showed a poor understanding of English and failed to grasp for some time that the patient was Mrs JH and not her daughter;
    b. He failed to examine Mrs JH in response to a history that she had fallen;
    c. When informed that JH's daughter (who suffered Multiple Sclerosis) could not look after her mother's personal needs, and asked to examine Mrs JH, he examined her in an extremely rough manner, "almost pulling her off the bed and causing her to cry out in pain";
    d. His suggested management was to give paracetamol;
    e. He caused such distress to Mrs JH's daughter that she asked him to leave;
    f. Mrs JH was admitted to hospital the next day by her own GP.

    We do not know what was the diagnosis in hospital or what treatment was necessary, if any, related to her fall.
15. Dr Schneider's response was by a letter of 23 October (wrongly dated September) 2005. He said he spoke first to the daughter and son-in-law in order to obtain a history, and they were insisting on a hospital admission. He then examined the patient; it was unrevealing. He then "helped her to leave the bed and do some steps". He said he only found tenderness on tapping the thoracic vertebrae area and there was no haematoma, laceration or graze. He therefore decided paracetamol, which was well tolerated, could be increased to 2 tablets every 4 hours. He said he had advised that the GP should be called the next day if there was no improvement. The rough and rude manners described in the complaint were said to be not like him, but if it appeared so he did not mean it and was sorry.
16. Dr Schneider's clinical notes were recorded electronically on the OOH computerised call system.

<u>(2) Mrs PP</u>

17. The second patient consultation was on Saturday 20 November 2005 with a Mrs PP. She was suffering a urinary infection, following her discharge home from hospital where she had undergone a knee replacement. In consequence she had had several falls, including on that morning when her daughter (the complainant) found her at 8.00:

    > "very distressed, she said she had been banging on the wall but no-one came – she seemed to think she was back in hospital and did not know where the alarm cords were. She was also incontinent and the bed and her own clothing were soaked. I tried to lift her but she screamed in pain when I touched her head and I was not able to change her – or indeed to give her any drink or food."

18. Mrs PP's daughter called the OOH doctor service and Dr Schneider arrived at about 10.30 hours. She complained (among other things) that when Dr Schneider had lifted her head to try to give her a drink, Mrs PP had screamed out, but the doctor had said this was no different than it would be in hospital. The nub of her later complaint was that she was "completely disgusted that anyone would leave an old lady (83 years) in a very weak and obviously dehydrated condition to lay in a soaking wet bed and clothing for two days with no attempt to give more help than suggest paracetamol. He believed the head pain had been called [sic] by the fall, yet still seemed unconcerned". Her letter of complaint alleged that after making a further call to the OOH service two rapid response nurses were sent, who changed her and the district nurse arranged admission to hospital by ambulance. Mrs PP was put on a drip to rehydrate her, and made a rapid recovery thereafter.
19. Dr Schneider's response was by a letter dated 15 December 2005. He said that Mrs PP's daughter had insisted on a speedy hospital admission, and that she could not cope with the situation, nor was able to care for her mother or give her any drink or food. He said he had examined Mrs PP and could not see any severe injury; no haematoma, no laceration and no graze. He described her circulation as OK and her neurological status as "well". He said he had diagnosed "a slight dehydration" and emphasised the need to drink a lot and take 2 paracetamol every 4 hours "for the pain of the head". He also said he had himself given Mrs PP a drink and she was able to drink. He did not consider admission to hospital to be necessary, and advised the daughter to tray and manage the care with some help. In fact Mrs PP's daughter's letter of complaint pointed out she was an only child with no other help other than a carer who attended for 15 minutes in the morning and that the two of them had been unable to manage to change her mother.
20. Dr Schneider's clinical notes recorded findings of a dry tongue, clear chest, blood pressure of 150/80, pulse 84 (reg) and she could move her arms and legs. He found her to be "oriented at the moment", reflexes equal and present. His diagnosis was "condition after knee replacement, condition after falls, slight dehydration".
21. When later questioned by Dr Kadri on the telephone about the technical aspects of assessing hydration status and managing social concerns, the latter found some difficulty in pursuing the questioning as "it was not always clear that Dr Schneider had fully understood the phrasing of questions being put to him on these issues".
22. The third complaint arose from a call-out to see Mrs NW, an 83 year old bedridden lady, on 17 December 2005. She was found by her daughter having apparently fallen out of bed, with a very badly bruised leg, cold and shaky. Her breathing was also becoming difficult. She called NHS Direct. It was noted on the computerised record that Mrs NW had fallen and been on the floor for 4 hours was now back in bed and had pain in both legs generally. In due

course Dr Schneider attended. Meanwhile NW's regular evening carer had arrived, and was present at the consultation. Mrs NW's daughter complained in writing that Dr Schneider:

a. Failed to diagnose or suspect that NW had fractures of both lower legs;
b. Was more than a little rough with her mother, causing her to cry out in pain;
c. Advised her she had not damaged her legs only bruised them, and advised she should take paracetamol;
d. Dismissed a suggestion from the carer that NW should be taken for x-ray of her legs;
e. Did not comment on her chest even though her breathing was clearly impaired;
f. Treated NW in an abrupt manner with a diagnosis that appeared rushed and obviously totally incorrect, and caused her to suffer needless pain before her admission to hospital a full 24 hours later.

NW's daughter reported that her mother had taken no food or fluids over the next day, and it was the carer who insisted on calling an ambulance the following evening.

23. NW's carer supported the complaint with a written statement to the effect that whilst Dr Schneider was examining NW he caused her to scream out in pain and said that her legs were only bruised. "I asked the doctor if [NW] needed to go to the hospital for an x-ray. He told me rather curtly that there was no need for that as her legs were just bruised".
24. On admission to hospital it was discovered Mrs NW had bilateral tibial fractures and respiratory distress. She died in hospital on 20th December 2005, the cause of death being given on the certificate as renal failure. Dr Kadri's report to the PCT committee indicated that this renal failure may relate to reno-vascular collapse as a result of her fractures, blood loss and muscled trauma but further detail was not available.
25. Dr Schneider's clinical notes were on this occasion hand written:

"O/E blue swelling both lower legs, movement of the knees and hips OK. BP 130/80, pulse 84 (irr[egular]) chest: slight wheezing.
Op: Condition after fall, bruise both lower legs. [illeg]
The daughter has paracetamol will give for the pain 2 tablets every 4 hrs.
If no improvement will call back or GP on Monday."

26. Dr Kadri questioned Dr Schneider about this consultation. Dr Schneider said he had noted bruising of both lower legs but thought the pain on examination was due to her lying on the floor for an extended period of several hours and the bruising was due t soft tissue trauma. Dr Kadri asked him what features he would look for to confirm a fracture in the lower legs. He mentioned a palpable break or rub. No other answers were forthcoming. Asked why he had not felt it necessary to carry out an x-ray to exclude a fracture, in light of his finding of extensive bruising of the legs and the suggestion that NW had screamed and cried out in pain, he said that with hindsight he would refer for x-ray in the same situation. He denied being rushed, or having any personal health issues which would have affected his

management. We have also seen an email from Dr Schneider to Dr Kadri dated 21 April 2006, about his management of this case.

27. We noted that when advising the Screening Panel Dr Kadri had said that during his conversations with Dr Schneider he "was unable to have a clear dialogue as there was an issue regarding the level of communication and understanding". It was also felt that Dr Schneider did not give appropriate answers, could not respond to basic factual questions and was unable to understand rational questions. Dr Schneider was felt to be inexperienced in trauma and A & E or primary care work, and did not demonstrate experience with elderly patients. The issues noted at paragraph 13 above were identified.
28. Dr Schneider saw the Screening Panel findings and responded by a letter dated 4 July 2006. He acknowledged this appeared to describe a doctor with a lot of deficiencies, and said "How can I defend myself with so many mistakes?". He informed the PCT that he had come to England 25 times for OOH weekends, between September 2004 and December 2005, during which time he had treated at least 700 patients. He acknowledged he was wrong not to order an x-ray of NW's legs. He defended his first line of pain management with paracetamol on the basis that it was available, tolerated in the past, and each had been told to call back if no improvement appeared. He admitted he would never speak English like a native but had attended an intensive training course and continued to have private tuition for 2 hours a week. He concluded by saying that he had worked for 22 weekends without complaint and suddenly had 3 weekends running where there were complaints. He wondered if it had something to do with local press interest in German doctors operating in Southampton.
29. The Reference Panel of the PCT held its hearing on 11 July 2006 and found consistent and serious concerns about the issues identified at paragraph 13 above. The hospital x-rays of Mrs NW had shown bilateral fractures of both tibial shafts running into the tibial plateau with some depression of the plateau in both cases, and the panel therefore expressed surprise that Dr Schneider could have found that "movement of knees and hips OK". The x-ray findings were felt to be more consistent with the daughter's account that Mrs NW screamed and cried out in pain. All panel members expressed the view that he could not provide a safe level of care for elderly patients who were an important part of the patient population he had to deal with. It was felt that no sanction other than removal was appropriate.

<u>Findings</u>

30. We find that Dr Schneider has shown serious and persistent clinical deficiencies:
    a. He failed (at the very least) to arrange x-rays to exclude fractures in the case of Mrs NW. We find it particularly surprising that he dismissed the well-informed concerns of her professional carer that an x-ray should be done.
    b. He failed to take an adequate history in the case of Mrs NW or to examine her properly: we share the PCT panel's view that it is difficult to see how the x-ray

findings can be reconciled to his assertion that movement of knees and hips was OK, and at the very least provides cogent evidence of inappropriate and insensitive examination technique and poor communication.

c. He showed inadequate knowledge (even after he knew of the diagnostic error in the case of Mrs NW) of basic assessment techniques to confirm or exclude a fracture.
d. He failed to recognise that Mrs NW's respiratory compromise required some investigation and management.
e. He failed to carry out an adequate assessment of Mrs PP, or to recognise the nature and degree of dehydration. She was disoriented in time and place shortly after 8 am, on her daughter's account, and had no fluids between then and Dr Schneider's examination, and we are unable to accept that she was sufficiently better by then to support his noted finding that she was "oriented", or that she was suffering merely "slight dehydration". We noted that 6 hours after his visit, the hospital found it necessary to institute rehydration by giving IV fluids, and that this was successful.
f. He failed to communicate with or heed Mrs PP's daughter adequately. Had he done so he would have recognised that it was highly unlikely that Mrs PP could receive basic essential care so as to receive enough fluids by the oral route, and/or to be changed out of urine soaked clothes and bedding.
g. His handling of all three patients was in some respects inappropriate and (in some cases) rough.
h. He performed an inadequate assessment of Mrs JH, communicated inadequately with the patient's family carers, and behaved in a manner which caused them to ask him to leave the house.
i. He made poor clinical notes, including failing to demonstrate a full assessment or to make a proper diagnosis.
j. He failed to demonstrate, when questioned by Dr Kadri, any adequate understanding of questions about assessing hydration status.
k. He failed to refer patients to hospital where appropriate or consider involvement of other agencies, if necessary (or if he was unsure of the available local support agencies) by referral back to the OOH services with an appropriate request.

31. One area where we were not satisfied that Dr Schneider was substandard was in his resort to paracetamol in the first instance for pain control. Prescribing more potent painkillers to the elderly may have unintended side-effects, and caution is therefore understandable, so long as the patient is reviewed and managed appropriately in other respects. This is not to excuse merely prescribing paracetamol for an elderly patient with two broken legs.

32. In our view, however, the investigative process undertaken by the PCT produced additional serious concerns about his ability to understand questions and to produce answers to basic medical assessment questions.
33. Dr Schneider showed, in our view, lack of insight into the nature and extent of his deficiencies, despite his admission that the Screening Panel's findings describe a doctor with a lot of deficiencies. Nor do we think that the fact that he had generated written complaints on "only" 3 successive OOH weekends in the Southampton area when the previous 22 had not generated complaints is a point in his favour. In our view that is an unacceptable level of complaint from patients' families. We judged these complaint letters to be measured and balanced. They have the common feature of being written by apparently well-educated families who were each involved in the day-to-day support of an elderly frail relative. We would be very concerned about the efficacy and competence of Dr Schreiber if called to a patient whose family was not so intimately involved, or was unable to give a coherent history and persist until the point was got across.

Conclusion

34. In light of our findings we are therefore satisfied that Dr Schneider was seriously deficient in the following areas which the PCT had previously found proved as a basis for removing him from its Performers List:
    a. Unsatisfactory assessment of patients
    b. Poor communication
    c. Lack of insight into the care needed for elderly patients
    d. Inappropriate action taken
    e. Notes do not demonstrate a full assessment.

    We do not think these are isolated incidents but demonstrated a worrying pattern, over a wide range of core skills which are crucial to a General Practitioners' work, particularly one working in OOH services and dealing with a significant number of elderly or vulnerable patients. These deficiencies are not essentially local in character. Patients were put at risk in the Southampton area and would be equally at risk in another PCT area.
35. We have given careful consideration to whether there is any sufficient evidence that Dr Schreiber has undertaken or will undertake remedial training directed to the deficiencies which have been identified, but there is no such evidence, other than his account of receiving 2 hours English tuition per week. In all the circumstances we cannot be satisfied that these problems are being, or will soon be, put right.
36. Balancing the need to protect patients and the efficient use of NHS resources against Dr Schneider's proper interests in preserving his access to opportunities to practise his profession within the NHS, we are in no doubt that national disqualification is necessary and proportionate.

37. We therefore direct that Dr Wolfgang Schneider (GMC Registration Number 6087288) shall be disqualified from inclusion in the following lists mentioned in Regulation 18A of the Performers Regulations, namely a Performer's List, a list referred to in section 49(N) 1 of the 1977 Act prepared by a Primary Care Trust, and any supplementary list prepared by a Primary Care Trust. We further direct that a copy of this decision be sent to the bodies or persons listed in Rule 47 of the Family Health Services Appeal Authority (Procedure) Rules 2001, namely:
    - The Secretary of State for Health,
    - The Registrar of the General Medical Council,
    - The National Assembly for Wales,
    - The Scottish Executive,
    - The Northern Ireland Executive Committee.
38. In accordance with Rule 42 (5) of the Rules we hereby notify the parties to these proceedings that either can appeal this decision under Sec 11 Tribunals & Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the receipt of this decision. Under Rule 43 of the 2001 Rules a party may also apply for review or variation of this decision no later than 14 days after the date on which this decision is sent.

29 November 2006

Duncan Pratt
Chair of the Panel