CASE NO. FHS14037

IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

Mr. D Pratt - Chair
Dr R Rathi - Professional Member
Mr R Rhodes - Member

BETWEEN:

DR SYED KHADRI
(GMC No. 1557369)

Appellant

-and-

NEWCASTLE PRIMARY CARE TRUST

Respondent

DECISION AND REASONS

1. On 1st September 2007 this Panel dismissed the appeal of Dr Syed Khadri ("Dr Khadri") against his removal from the Performers List of Newcastle Primary Care Trust ("the PCT") on the ground that his inclusion in the List would be prejudicial to the efficiency of the services which those included in the List perform. In other words this was an "efficiency" removal under Regulation 10(4) (a) of the National Health Service Performers List Regulations 2004 ("the 2004 Regulations"). We further directed the removal of Dr Khadri from the PCT's Performers List.
2. At that time we were not asked by the PCT to consider the question of national disqualification and we did not do so. Consequent upon receipt of our decision and our reasons set out within the decision, by a letter dated 26th September 2007 the PCT now invites us to consider a national disqualification of Dr Khadri (that is to say from all Performers Lists maintained by any PCT in England and Wales). The PCT's letter indicates it is doing so in accordance with Section 49N (4) of the National Health Service Act 1977, as amended.
3. We reconvened to consider the matter on 10 December 2007. The PCT was content for the matter to be determined on the papers, namely its letter of 26th September and the reasoned decision we gave on the substantive appeal, but Dr Khadri wished to put submissions to us at a hearing. In the event Dr Khadri did not attend, because he was on a religious pilgrimage

abroad, but was represented by Ms Clare Chapman of RadcliffesLe Brasseur, solicitors. The PCT attended through Ms Amy Matthews, of Hempsons, solicitors, in a noting capacity only.

4. At the outset we indicated to Ms Chapman that although the PCT had specifically invited us to consider national disqualification under Section 49N (4) of the 1977 Act, we were minded to consider the matter also under our powers pursuant to Section 49N (1) and Regulation 18A (2) of the 2004 Regulations (see below) and asked whether she had any objection or submission. She told us she did not. We therefore approached this as a reconvened hearing to consider, at the invitation of the PCT, national disqualification, following our dismissal of Dr Khadri's appeal.

DECISION

5. Our unanimous decision is that Dr Khadri be disqualified from inclusion in any list, prepared by a Primary Care Trust, as is referred to in Section 49 N (1) of the National Health Service Act 1977, as amended.

REASONS

The Legal framework

6. By Section 49 N of the NHS Act 1977 as amended:

> "(1) If the FHSAA removes the practitioner from a list, it may also decide to disqualify him from inclusion in – (a) all lists [prepared by all PCT's]….
>
> (2)….. referred to in this section as the imposition of a national disqualification…..
>
> (4) The [PCT] may apply to the FHSAA for a national disqualification to be imposed on a person after they have –
>
> (a) removed him from a list of theirs of any of the kinds referred to in subsection (1) (a) to (c) ….."

7. These provisions are mirrored in Regulation 18A (2) and (3) of the 2004 Regulations (as amended):

> "18A (2) If a performer appeals to the FHSAA under regulation 15 and the FHSAA decides –
>
> (a) to remove the appellant from a performers list; or….
>
> the FHSAA may also impose a national disqualification on that performer.
>
> (3) A Primary Care Trust which has –
>
> (a) removed a performer from its performers list; or ….
>
> may apply to the FHSAA for a national disqualification to be imposed on him."

8. If national disqualification is imposed, the practitioner may not request a review until two years have expired, and thereafter at yearly intervals: Regulation 18A (8) of the 2004 Regulations and Section 49(N) (8) NHS Act 1977.

9. There is no statutory guidance on the factors to be applied in considering national disqualification. The "Advice for Primary Trusts on Lists Management" published by the Department of Health in 2004 says at paragraph 40.4:

> *"The effect of a national disqualification is to prevent a doctor being included in the Performers List of any PCT in England. Decisions of an individual PCT can only have effect in the area for which that PCT is responsible. As a result there is a risk that a doctor who has been removed from the list of one PCT may go on to offer his services to PCTs in turn in the hope that he will find one prepared to accept his services as a performer...This additional sanction is necessary in the most serious cases, only when a doctor has been refused admission to a PCT list or has been removed by a PCT from its own list, and it is imposed by the FHSAA…Unless the grounds for a removal or refusal to admit decision were essentially local, it would be normal to give serious consideration to such an application."*

The principles derived 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 serious and are not by their nature essentially local to the area where the practitioner was working;
b. National disqualification arises more readily in, but is not confined to, "unsuitability" cases; each case must be looked at on its own merits, and on all the information available;
c. It is a serious measure, likely to affect adversely the ability of the practitioner to pursue his or her profession within the National Health Service;
d. It is necessary to consider whether national disqualification is proportional to the mischief of the Panel's findings as to the 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).

<u>Summary of relevant findings and background to this decision</u>

10. The ground for Dr Khadri's removal from the Performers List was, as we have indicated, an "efficiency" ground, but this arose from serious and wide-ranging clinical deficiencies which we judged were not capable of being remedied by Dr Khadri within any reasonable time frame. We refer to but do not repeat our extensive findings in the decision dated 1st September 2007. At the outset of that hearing Dr Khadri accepted that his work was currently below the standard required to practise as a GP and he required a period of retraining. The real issue between the parties at the substantive appeal was whether he should be contingently removed, by the imposition of conditions requiring retraining, or whether he should be removed outright.
11. Among other things, we found that:

a. There were significant deficiencies over a wide range of core clinical competencies [para 65], demonstrated on NCAS assessment, two MCQ assessments for the Northern Deanery, and indeed admitted by Dr Khadri;
b. The range of those deficiencies was such that:
    i. It was difficult to know where his basic core knowledge began and ended [para 65];
    ii. He represented a significant risk to patients [paras 72] ;
    iii. The training courses run by the Northern Deanery (or any other postgraduate Deanery) would not address that gap in basic knowledge, which had to be assumed before a doctor could access the retraining or return to work programmes [paras 65 and 68].
c. Dr Khadri lacked the aptitude to improve to the required entry level for a retraining course [paras 68 and 70];
d. Training (even if he accessed it) was unlikely to be effective, given the law scores he had achieved, without any significant improvement over the period of testing [paras 68 – 71];
e. Dr Khadri lacked real insight into his faults and deficiencies and what was necessary to make them good, and did not find it easy or possible to acknowledge that the fault lay with anyone but himself [para 69];
f. There was no realistic prospect of Dr Khadri securing an accredited training place with a Deanery or satisfactorily completing any training [para 70].

12. We found that Dr Khadri's inclusion in the List was prejudicial to the efficiency of the services, and that there was no realistic possibility of curing the defects identified by the PCT, by the imposition of conditions, even if appropriate conditions could be framed, which in our view they could not: conditions may only be imposed "with a view to (a) removing any prejudice to the efficiency of the services in question …" [Regulation 12 (2) of the 2004 Regulations].

Submissions

13. The PCT relied on its letter dated 26th September 2007, namely that in light of the decision to dismiss the appeal, and mindful of its responsibility to patients and the wider NHS, and because the matter giving rise to the decision extended far beyond what might be considered local issues, the PCT wished to request us to consider national disqualification. They relied on the findings and reasons set out in our previous decision. They made no further submissions to us at the hearing.
14. Dr Khadri's representative, Ms Chapman, submitted that our power to impose national disqualification was discretionary and nothing had happened since our consideration of the substantive appeal to put Dr Khadri's deficiencies in a worse light. Moreover there was no risk of Dr Khadri seeking employment from another PCT.

15. She informed us that he had been suspended from the Register by the Interim Orders Panel of the General Medical Council (this was in May 2007) and that had recently been confirmed (unopposed) on a review in November 2007. Suspension under these provisions could run for 18 months to November 2008 (or earlier determination of his referral), or could then be extended by application to the High Court.
16. Meanwhile Dr Khadri had been requested by the GMC to undergo a Performance Assessment and had agreed to do so in September 2007. He awaited notification of when and where this was to happen. In Ms Chapman's experience this might take 6 months, after which he would have an opportunity to make representations, and the matter would then by referred to a Fitness to Practise Panel of the GMC which would consider the findings of the Performance Assessment and decide whether Dr Khadri's fitness to practise was impaired and if so what sanction might be appropriate. She indicated that if there was a likelihood of serious sanction Dr Khadri might consider applying to be removed from the Register in any event.
17. In light of his current suspension from the GMC Register, and hence from being able to practise medicine at all, Ms Chapman submitted that the protection of patients was adequately achieved. She submitted that Dr Khadri had co-operated throughout with all authorities and submitted to requests to test his clinical abilities and health. She pointed out that he had acknowledged his clinical shortcomings and that he would not return to practise until they were remedied: she drew attention to the passage of his witness statement which we quoted at paragraph 7 of our decision. She said that he had no intention of applying to any PCT unless and until this was permitted by the GMC.
18. Ms Chapman did submit, however, that it was possible that the GMC might consider imposing conditions on his registration in the light of the results of his Performance Assessment, and that would offer the prospect of returning to work which would be thwarted if Dr Khadri was nationally disqualified.
19. She therefore submitted that national disqualification would be disproportionate.
20. In answer to questions from the Panel Ms Chapman confirmed that she did no submit the clinical deficiencies were not serious, nor that they were essentially local in character. She could give no more than a "might or might not" to the possibility of Dr Khadri being restored to the Register subject to conditions.

<u>Conclusions</u>

21. We approached this matter as a reconvened hearing as set out at paragraphs 1 to 4 above.
22. We have had regard to all the evidence considered by us in the course of the earlier appeal, our findings set out in our earlier decision, and the further information and the submissions put before us by Ms Chapman on behalf of Dr Khadri.

23. We are satisfied that Dr Khadri's deficiencies are serious, wide-ranging, and place patients at risk. We are satisfied that the deficiencies we identified are not peculiar to his practising in the Newcastle area, but would occur wherever he was and on whatever PCT Performers List. We are satisfied that there is no realistic possibility of Dr Khadri bringing his standard of practice up to an acceptable level within a reasonable time frame and probably not within the next two years.
24. While we acknowledge that Dr Khadri is currently suspended from the GMC Register and therefore unable to practise medicine (at least in the clinical setting) the progress and outcome of his referral to the GMC is inevitably speculative. In our view we cannot abdicate the responsibility of making a decision solely in reliance on the workings of the GMC. As has been said before by other FHSAA Panels, the roles of the FHSAA and the GMC are not entirely comparable and in particular the FHSAA is not a disciplinary body for the medical profession, but is concerned primarily with the interests of patients on NHS lists throughout England and Wales, and the preservation of the safety and efficiency of the NHS primary services provided to patients. In doing so we must balance the impact of any such decision on Dr Khadri.
25. Dr Khadri's clinical deficiencies made considerable depredations on the Newcastle PCT in a variety of ways outlined in our earlier decision. In our view no other PCT should be exposed to such risks, nor is it is appropriate to say that because Dr Khadri would be under a duty to disclose his removal from the PCT's List on a future application elsewhere, the mischief can be avoided without resort to national disqualification. National disqualification is there in part because it avoids the need to rely on the scrupulousness of disclosure of the doctor, or the efficiency of enquiry by another PCT.
26. We conclude that it is appropriate to direct that Dr Khadri be nationally disqualified from all Lists prepared by all Primary Care Trusts and all Health Authorities including but not limited to those referred to in Section 49N (1) of the National Health Service Act 1977 as amended.
27. This is not a case in which we consider it appropriate to make a direction under Regulation 19 of the 2004 Regulations as amended, that an application for review cannot be made until five years have elapsed.
28. Therefore Dr Khadri may request a review of this disqualification after the expiration of two years from the date of this decision. This decision shall be sent to the bodies identified within Rule 47(1) of the Family Health Services Appeal Authority (Procedure) Rules 2001.
29. Any party to these proceedings can appeal this decision under Section 11 of the Tribunals and Inquiries Act 1992 by lodging Notice of Appeal at the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from receipt of this Decision.

Dated the 10th day of December 2007

Duncan Pratt

DUNCAN PRATT