IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY **CASE 13046**

Professor M Mildred- Chairman
Dr H Freeman - Professional Member
Mrs J Alderwick - Member

BETWEEN

DR ARUN KUMAR RAUNIAR
(Registration Number 3457502)
Appellant

and

WALTHAM FOREST PRIMARY CARE TRUST
Respondent

DECISION WITH REASONS

Background

1. The appellant ("Dr Rauniar") is a general medical practitioner who from June 2003 until his suspension by the Respondent PCT ("the PCT") was practising at the Vicarage Road Medical Centre, London E10 as a single handed GP principal. Prior to that he had practised in partnership with Dr Kalra at Crawley Road Medical Centre, also in the area of the PCT. The suspension occurred as a result of a complaint by Ms #, the review by the PCT of an Independent Review Panel in response to a complaint against Dr Rauniar, a review of complaints against him since 2000 and a review conducted by Dr Mark Ashworth on behalf of the PCT of the case notes of 50 of Dr Rauniar's patients. This review produced criticisms of Dr Rauniar's care in 15 cases of which 2 were not pursued before us because it turned out that consent from the patients to their inclusion in the review had not in fact been properly obtained.

Procedural history

2. On 24 June 2005 a Panel appointed by the PCT heard an application to remove Dr Rauniar from its Performers Lists and decided by letter dated 29 June 2005 to remove him contingently, subject to onerous conditions [R1/99-100], on the ground that his continued inclusion on the List would be prejudicial to the efficiency of the services provided. References in this decision to documents are expressed by bundle number and page number, eg [R1/1] for page 1 of the PCT's first bundle.

3. Dr Rauniar began an appeal to the FHSAA by a letter from his solicitors dated 21 July 2005 and the PCT by grounds dated 23 August 2005 stated that it would contest the appeal. The Panel first established to hear the appeal decided that it should not proceed after a dispute over the admissibility of a number of

documents before it. The present Panel was accordingly established and gave directions in anticipation of a hearing to take place in July 2006. In the event Dr Rauniar was indisposed and the hearing was adjourned to 13-15 November 2006 at the Care Standards Tribunal.

The hearing

4. Dr Rauniar was represented by Mr Angus Moon QC instructed by RadcliffesLeBrasseur and the PCT by Mr Richard Booth instructed by Capsticks. All members of the Panel confirmed that they had no conflicts of interest in hearing the appeal. It was agreed that the PCT would present its case and that, in relation to performance allegations, the standard of proof for it to meet was the balance of probabilities.

5. The evidence called at the hearing fell into four parts: medical evidence on prescribing and clinical issues arising out of Dr Ashworth's review; the rest of Dr Rauniar's evidence; the specific complaint of Ms # and the condition of and facilities at Dr Rauniar's surgery. Rather than go through the evidence witness by witness we shall deal with the competing contentions of the parties on one subject at a time

The Ashworth Records Review

6. Dr Ashworth was called by the PCT on 13 November 2006 to prove his witness statement and the review prepared in conjunction with the then North East London SHA [R1/53-57]. He had seen the written but not the parallel computerised records at the time of his review. He accepted in cross-examination that he might not have had the full picture for this reason and accordingly described his review (and because he had not discussed the cases with Dr Rauniar) as a snapshot rather than the full picture.

7. Case 1: Dr Ashworth accepted that the computerised record contained a smoking history and that it was unnecessary and potentially offensive to ask a Muslim about alcohol history. He did not accept that the computerised record entry "no frequency blood in urine" meant that there was no haematuria, particularly because the written record said clearly that there was blood in the urine. He said that the fact that the urine test was negative for bacteria did not mean that, for example, chlamydia was excluded and said that the patient should have been referred to a STD clinic.

8. On re-examination Dr Ashworth said that further investigation was required but had not been arranged.

9. Dr Rauniar said that the record should have read "no frequency and no blood" but that he had forgotten to write that in full. He said he told the patient not to take the prescription until he had had the result of a urine test. He said that he never forgot to take a sexual history although he used oblique rather than direct questions to elicit it. He said that the manuscript note was made during the consultation and the computer note at the end of the consultation before the next patient arrived. He maintained that the prefix E meant that an examination had taken place.

10. On cross-examination he said he recalled both consultations from reading the notes. The patient said he had had blood in the urine and Dr Rauniar had performed a dip test that was negative for blood. He asked obliquely all relevant questions about STDs but did not record the answers for lack of time and because they were negative and he did not think it necessary to refer the patient to a STD clinic. He did not refer to the possibility in his witness statement because it was a short statement.

11. After a short break (at 1524 on 14 November) it was reported that Dr Rauniar was suffering cardiac symptoms and his evidence was interrupted while he rested and his wife was called. He returned to continue his evidence after approximately 15 minutes.

12. Dr Maurice James Healy gave expert evidence for Dr Rauniar in a report dated 6 March 2006 [R111-124] and in oral evidence on 18 December 2006. Although retired from full time general practice for 14 years, Dr Healy regularly acts as a locum. In general he supported Dr Rauniar's position that the note of a diagnosis required a prior examination.

12. In relation to Case 1 he accepted that a case of blood in the urine should be referred, if found, but asserted that Dr Rauniar had acted correctly in attempting to discover whether blood was actually present in the urine before making a referral. He accepted there was no reference in the notes to a STD but said Dr Rauniar had told him of his line of questioning of the patient. In re-examination he said Dr Rauniar was right to test the urine in the surgery and send a sample for an MSU.

13. Case 2: Dr Ashworth maintained that Praxilene was an ineffective treatment for intermittent claudication even if it might alleviate symptoms. He said that there had been a good examination but that the treatment was insufficient where there was a threat to the remaining leg of a patient who had already had one leg amputated and that extreme measures should have been taken to protect the patient. He had not been aware of Dr Rauniar's experience in vascular surgery but was unsure how much benefit that experience would have been in the case. He would have accepted the approach of Dr Healey, if the patient had not already lost one leg.

14. On re-examination he said that in any event the Praxilene should according to the BNF have been at 200 rather than 100mg tds. He criticised the decision to treat claudication without a Doppler test or any note of an examination. Dr Ashworth accepted that Dr Rauniar had some evidence of training in vascular medicine.

15. Dr Rauniar described how he took a history from this patient and then examined the colour of the leg and felt for pulsations. If there was any doubt, he used his own Doppler machine but since he felt pulsations, he did not use it in this case. Instead he used the Berger test for any colour change on raising and lowering the leg.

16. Cross-examined Dr Rauniar said that the prefix E in the EMIS system did not necessarily mean (in contrast to his evidence on Case 1) that an examination had taken place. It was rather a default coding that was not changed for fear of losing data in the change.

17. Dr Rauniar said that he saw the patient on 7 June 2004 and the 25 June entry was by the nurse completing the diabetic template to secure the QOF point. He said he had asked all the necessary questions and that the Berger test had been very good. He did not use the Doppler because he had felt a strong pulse.

18. By now it was clear that Dr Rauniar was unwell and, after a short break, the hearing was adjourned for the day. In the event Dr Rauniar was not well enough to attend on 15 November and the hearing was adjourned to 18 December.

19. When the hearing resumed on 18 December Dr Rauniar said in cross-examination that the absence of notes did not mean that he had failed to give the patient a full examination and that his decision to perform a Doppler test was for clinical reasons rather than pressure of time. He did not accept that Praxilene was of limited value despite saying exactly that in his witness statement. In reply to a question from Dr Freeman he confirmed that the patient was Afro-Caribbean.

20. Dr Healy said that an examination must have been done to arrive at a diagnosis. He did not realise that Dr Rauniar had not been involved in the consultations of 25 June and said that, if Dr Rauniar had been in any doubt, he should have referred the case. He said that Praxilene "will suit some people" and that it was correct to start with the lowest dose and increase it, if necessary. In re-examination he accepted that the patient's skin colour may have caused a problem in using the Berger test but that an experienced doctor could have satisfactorily dealt with it. If Dr Rauniar had been in any doubt, he would have used the Doppler test.

21. Case 3: Dr Ashworth accepted that there had been very detailed recording in the notes and had no criticism.

22. Case 4: In this case a prescription had been given for a glitazone that would have been contra-indicated in combination with insulin according to the British National Formulary ("BNF"). There was confusion over the date of prescription but it appears it was given approximately 5 weeks before the patient's appointment with his consultant diabetologist.

23. On re-examination Dr Ashworth said he did not know about the use of glitazones in other countries but did know they were not recommended by the BNF. Dr Ashworth said that, if Dr Rauniar had told the patient not to start taking the precription until he had seen his consultant, that would have been an insufficient warning because of the potential for serious harm.

24. Dr Rauniar's evidence was that he had known the patient a long time and therefore told him to ask his consultant whether he should take the glitazone, in

the meantime putting the prescription in reception for collection, if the consultant agreed.

25. In cross-examination he said this was a frequent practice and that the notes of the PCT hearing where he was recorded as saying that the patient had taken away the prescription [R1/86] were wrong. He described the facts that paragraph 3 on page 2 of his witness statement ended with a comma and that there was a considerable empty space at the top of page 3 as a printing error (rather than a redaction) [R1/137]. He said that he had forgotten to record in the notes that the patient was not to take the prescription until he had seen his consultant.

26. Dr Healy said that he would not criticise the prescription, if the patient had not started to take it but said a responsible GP should have noted in the records that the prescription should not have been cashed before the patient had seen the consultant. He would himself have written to the consultant to ask whether it was a good idea to prescribe a glitazone.

27. Case 5: Dr Ashworth criticised the prescription of Tibolone with no investigation or referral: Dr Rauniar's evidence was that referral was appropriate after 3 months trial on Tibolone and he withdrew any apparent concession in his witness statement that he accepted Dr Ashworth's view. Dr Healy accepted this case could have had very serious consequences and said that Dr Rauniar had accepted this in front of Dr Rodger, his representative at the PCT hearing.

28. Case 6: again Dr Ashworth found Dr Rauniar's records worthy of praise.

29. Cases 7 and 8 were excluded from consideration in the absence of the patients' consent to their inclusion.

30. Case 9: Dr Ashworth gave evidence that a negative finding on examination should be reported as much as a positive finding and said that it had been more serious not to examine the chest, rather than the throat. He thought Dr Rauniar had employed excellent clinical reasoning but the prescription of oral salbutamol was no longer good practice and attempts should have been made to try other forms of treatment before resorting to it.

31. On re-examination he said he thought the code "E" on the computer records must have been a default setting rather than evidence of an examination and that there was insufficient evidence on the records to allow a locum to know whether an examination had been performed on a previous consultation.

32. Dr Rauniar said that he gave the oral prescription because he knew it worked and the patient could not conduct a peak flow test. He did not train her to use an inhaler because of the discomfort and because her husband smoked at home. In cross-examination he repeated that he did not record negative findings and said that it was impossible to diagnose acute pharyngitis without an examination. Dr Healy concurred with this view.

33. Case 10: Dr Ashworth described the notes as particularly thorough even for a doctor who often wrote good notes.

34. Case 11: Dr Ashworth described the notes as inadequate and said that there was insufficient reasoning. It was not clear whether depression was a current issue. On re-examination he said he would have expected to see an assessment of the severity of the patient's depression and of the risks to the patient.

35. Dr Rauniar said he had taken a history from the patient whom he had known a long time after assuming that her sleeping problems were caused by depression. He asked her about coping, irritability, eating, sleeping and suicidal thoughts and the patient only admitted to not sleeping well. In cross-examination he said that his recording was adequate and he had prescribed amitryptilene partly to raise the pain threshold in view of the presenting symptom of bilateral elbow pain. It was put to him that Dr Rodger had said that there was inadequate recording but Dr Rauniar did not accept this.

36. Dr Healy supported the prescription in the light of two out of five symptoms being present: not reporting the patient's mood could be excused in view of the presenting symptoms. Amiltryptilene was useful for raising the pain threshold and as a sedative (although a larger dose would have been indicated for this purpose).

37. Case 12: Dr Ashworth's view was that he had assumed that a full neurological examination had not been carried out but that the patient's history alone justified a specialist referral. On re-examination he said that migraine was a possible differential diagnosis but that in the presence of a red flag symptom the doctor should not assume a less serious cause of the presenting symptoms.

38. Dr Rauniar described carrying out a neurological examination via smell, visual field test, pupils, eye movements, face, sensation, seventh nerve, tongue, motor and 5 reflexes from which he received no positive signs. He did not make a note of the examination because of the pressure of time. For that reason his practice was to record positive findings only.

39. In cross-examination he said that the entire examination could be done in 5 minutes and that he could not have made a diagnosis without an examination. He described a smell test using deodorant spray on a cotton bud. A referral was not merited because there was no rigidity in the patient's neck 12-14 hours after the onset of his explosive headache.

40. Dr Healy said that Dr Rauniar had told him all the steps he had taken in making his examination and that he had not had time to record them. Dr Rauniar would have had appropriate experience from working in Accident and Emergency. He said that exertional migraine was well known although he accepted there was no history of migraine in this patient. Dr Healy had never heard of using a deodorant spray for a smell test and said he would himself have referred this patient because he had not had Dr Rauniar's neurological experience.

41. Case 13: Dr Ashworth said that Dr Rauniar had purely coincidentally arrived at the right prescription but for entirely the wrong reason and that the patient's condition could not have been episcleritis (which never causes blurring of sight), that the blurring was a " red flag" symptom and that treating presumed conjunctivitis with Maxitrol was dangerous. The blurring was potentially eye-threatening and the patient should have been referred urgently.

42. In cross-examination Dr Rauniar said he did not recall telling the Independent Review that he did not have time to use fluorescein. He used steroid eye drops when other drugs were not effective and did not accept the BNF view that corticosteroids should only be used under expert supervision. He accepted that it was not appropriate to use steroid eye drops to treat chronic conjunctivitis and prescribed Maxidrex on this occasion because, although the patient thought she was suffering from conjunctivitis, she was in fact suffering from episcleritis. He disagreed that uveitis (the consultant's eventual diagnosis) was different from episcleritis or conjunctivitis.

43. Dr Healy agreed that the fluoroscein dye should always be used in case of doubt and that Maxitrol was not effective to treat conjunctivitis. In re-exam ination Dr Healy said that uveitis was the likely diagnosis on 14 August and that this was different from conjunctivitis because the latter involves pus in the eyelid and matting of the eyelashes. If the patient was in fact suffering from uveitis the prescription had been correct in fact, but by chance. In reply to Dr Freeman Dr Healy conceded that Dr Rauniar had not satisfied himself, as Dr Healy contended, that there was no infection of cornea, viral or herpetic because Dr Rauniar had not used fluorescein for this purpose. If Dr Rauniar had seen pus, he would have concluded that there was a bacterial infection although Dr Healy again conceded that there was no evidence that pus was present.

44. Case 14: Dr Ashworth only criticised the amount of work-up of the patient before referral.

45. Case 15: Dr Ashworth criticised the adequacy of "tightness of chest" as a history and said that an immediate referral to hospital should have been considered. There was an inadequate record of the examination and the basis for the prescription. The treatment with oral salbutamol was incorrect and the patient's consultant requested before seeing the patient that it be stopped immediately. In reply to a question from Dr Freeman Dr Ashworth described this as very unusual.

46. In general Dr Ashworth described Dr Rauniar's record keeping as at least as good as average but his patient safety performance as much worse than the average and his awareness of and reaction to red flag symptoms as much worse than average.

47. Dr Rauniar said that he had asked the patient appropriate questions about her chest pain and she denied pain at rest, the presence of which would have led him to call an ambulance. He made what he described as an urgent consultant referral and was of the view that there was no useful medication in the light of the patient's complicated history. He did not make an immediate referral

because he believed that Frusemide would bring down the patient's blood pressure.

48. In cross-examination Dr Rauniar disagreed that oral salbutamol was inappropriate and said that he prescribed Frusemide because of the patient's high blood pressure: he knew that it could contribute to uncontrolled atrial fibrillation but said he knew the patient well. He was aware that cardiac problems can present as chest pain and maintained that the patient's pulse rate was not particularly rapid compared with past readings although it was put to him that it was, at the consultation, very much faster than had been in recorded in the notes over the preceding two years.

49. Dr Healy said that he would have been worried that this patient had ventricular failure and the rise in pulse rate from 81 to 110 would have been of concern. He accepted that there was no evidence of a detailed examination on 19 March and that tightness and exertional shortness of breath could be signs of ventricular decompensation. He also accepted it was very exceptional for a consultant to write to ask a GP to take a patient off a drug even before seeing that patient.

50. In general Dr Healy accepted in cross-examination that there was limited evidence to support what Dr Rauniar had told him he had done with the various patients and that Dr Rauniar had not as much insight into his practice as he would like to have seen. He accepted that the absence of harmful outcomes was not the correct way to assess management of patients by a GP but thought that the stress of the hearing had increased Dr Rauniar's anxiety. He accepted that Dr Rauniar's management of cases 5, 12 and 13 at least gave cause for concern. He further accepted in reply to Dr Freeman that he would have expected negative findings of significance to be recorded in patients' notes and that Dr Rauniar's record-keeping was "very scanty".

<u>Dr Rauniar's other evidence</u>

51. In evidence in chief Dr Rauniar referred to the administrative and financial problems that had arisen at the Crawley Road practice and led to the acrimonious breakdown of relations with his partner Dr Kalra. The warning from the GMC in 2001 was understood by Dr Rauniar to be a complaint about not seeing a patient rather than a complaint about the prescription of steroid eye drops. In any event he said he had paid attention to it.

52. He perceived the complaint giving rise to the first Independent Review Panel as resulting from the ill-will of Dr Kalra whose patient he had refused to see. He did not deal with the criticism of his response to the patient's complaint.

53. Dr Rauniar told us he had only received the report of the second Independent Review Panel after his suspension. The assessors had disagreed about the clinical and prescribing aspects of the complaint. Since his suspension he has funded training to improve his communication skills, consulted Professor Skelton and read books and watched a DVD recommended by him. Dr Rauniar described the model consultations shown on the DVD as just like his own.

54. In relation to the third Independent Review Panel Dr Rauniar said he had only ever received the clinical assessors' report. He defended the use of the record "rattley chest" as meaning that he had conducted a chest examination at which he heard no particular sound and was unable to come to any definite conclusion. The assessors had recommended mentoring to ascertain the degree to which Dr Rauniar's clinical knowledge and judgement fell short of that of the average GP.

55. Dr Rauniar was unable to explain the fact of 32 complaints against him between 2000 and 2003 and pointed out that there had been only 3 at Vicarage Road in a year. His general position was that the complaints were not well grounded.

56. On cross-examination Dr Rauniar described his system of record keeping further. If something was minor, he would write it in only one record. For chronic disease management he would use both systems. There was no hard and fast rule about which method he used. He would only write positive findings on examination. He would not use "O/E" since he did not believe in abbreviations and some locums might not understand them.

57. If a patient presented more than one complaint, he would deal with the second, if it was minor and otherwise tell the patient to make a new appointment.

58. He did not accept there was a large number of complaints in 2000-2003 and said that the summaries were produced without his knowledge in the context of an acrimonious partner dispute. When the first independent review was put to him he said that it was wrong to discuss the past. He also said the reviews had been instigated by his partner and that either he had not received the three reports or that he had been too busy at the surgery to read them.

59. Dr Rauniar seemed partly to accept the breach of confidence in the complaint at R2/11 but also said that, if a mother talked about her son, that was permission to discuss the son's condition. He said that he did not like patients coming back to bother him. When asked whether he accepted that patients might have a more serious concern than the first matter they raised in a consultation Dr Rauniar replied that patients should say exactly what they wanted rather than asking absurd questions and wasting his time. Again he said that he thought his partner was instigating patients to make visits or provoke complaints.

60. Responses to complaints were put to Dr Rauniar and he told us he did not understand what was wrong with the tone of them. [R2/23]. In re-examination he confirmed that his apology in relation to the breach of confidence was sincere, that he had no knowledge of the ten complaints against him between April 2000 and May 2001, that he had had experience at Bishops Stortford of vascular surgery and of the treatment of head injuries and that he had been on an ophthalmology course in Colchester in 1993 or 1994.

<u>The Vicarage Road Surgery</u>

61. Glen Ridout, a lay assessor then working for the SHA, gave evidence on 13 November 2006 about his visit to the practice on 5 January 2006 and his subsequent report [R1/48-52]. He was cross-examined on the basis that he accepted criticisms of the practice by the receptionists without putting them to Mrs Rauniar and failed to attempt to put them right. In any event on the date of his visit Dr Rauniar had been suspended for some months and the PCT had installed a practice manager to take Mrs Rauniar's place.

62. Sudama Rauniar, the wife and practice manager of Dr Rauniar, produced her witness statement as her evidence in chief [A1/92-95]. She claimed there were no problems in the Vicarage Road practice before Dr Rauniar's suspension and the appointmant by the PCT of Ms Sezin Osman as practice manager. Her statement took issue with a number of points in Mr Ridout's report, in particular that late patients were referred to the Whipps Cross Walk-In Centre and drew attention to the deterioration of the practice since the suspension of Dr Rauniar.

63. Cross-examined, Mrs Rauniar told us she was not involved in the selection of cases for Dr Ashworth to review and confirmed that there was now a very bad relationship between her and Ms Osman and the receptionists.

Complaint of Ms #

64. On 14 November # gave evidence about her unsuccessful consultation with Dr Rauniar on 18 June 2005. In essence she complained that Dr Rauniar refused to help her change her maternity booking from Whipps Cross to Homerton Hospital, refused to deal with her until he had direct evidence of her pregnancy and refused to listen to her main concern which was that she had developed bleeding piles.

65. She was cross-examined on discrepancies between her statement for this appeal and the minutes of the PCT Panel hearing at which she had given evidence. She had drawn attention in her witness statement to two matters. She said that the minutes were wrong in saying that she told Dr Rauniar she had thrown away her home pregnancy test: she said she had left it at home. She described herself as more perplexed than irritated by Dr Rauniar's attitude to her requests to transfer her care and be treated for her piles. She denied being violent or threatening and said that she felt attacked, uncomfortable and unhelped.

66. The reference in the PCT minutes to her thinking what happened was "humorous" was intended by her to mean that she found it humorous that Dr Rauniar had accused her of violence. She was certain she had raised the topic of her piles at the consultation. On 23 July 2004 Ms # went to Homerton Hospital A & E because she was bleeding pv and feared she was losing her baby. She had not mentioned her piles because they were much improved by then and she was preoccupied by what she believed was a threatened miscarriage.

67. On re-examination Ms # said that she understood for the first time that Dr Rauniar was accusing her of being aggressive when she received his response to her complaint.

68. Dr Rauniar in cross-examination said that he considered his reply to Ms #'s complaint acceptable. He was not aggressive towards her and she never mentioned her piles.

The FRCS issue

69. At this point Mr Booth drew Dr Rauniar's attention to his practice letterhead on which he included in his qualifications FRCS. It had already been noted by the Panel that in the CV annexed to his witness statement for this appeal he had qualified this to include the words "Primary (Part I)". Mr Moon objected to questions about this on the grounds that (a) this issue and the document had not been before the PCT Panel; (b) he had not had notice of it; (c) it was not a ground relied on in the PCT's reply to the appeal; (d) the PCT had no right under r. 41(7) of the FHSAA (Procedure) Rules 2001 to adduce new evidence; (e) the fact that Dr Rauniar had produced the document did not mean that it was brought into evidence by him unless it had been referred to in evidence in chief, which it had not and (f) it was the subject of proceedings in another forum.

70. We overruled the objection on the grounds that (a) the credibility of witnesses had been put into issue by Dr Rauniar, as had Dr Rauniar's surgical expertise; (b) he had had notice of the potential line of questioning by putting the document into the hearing bundle; (c) by questioning Dr Rauniar on his credibility by reference to the document the PCT was not advancing a new ground of reply or calling new evidence and (d) it could not be right that Dr Rauniar could avoid such questions by failing to refer to the document in evidence in chief when that document was relevant but clearly against his interest and (e) conversely, the witness statement he had chosen to produce and thus stood in part as his evidence in chief expressly referred to the CV.

71. In response to questions from the Chair Dr Rauniar accepted that he was not a Fellow of the Royal College of Surgeons and that FRCS had been on his letterhead since his time at Crawley Road. Mr Booth's attempt to cross-examine him on this matter in relation to his insight was not allowed by the Panel.

Dr Rauniar's testimonial evidence

72. Mr Mohammed Bangladesh produced his witness statement that described, in addition to praising Dr Rauniar's practice unreservedly, the establishment of a patients' association in an attempt to restore Dr Rauniar to work [A1/254].

73. Mr Moon also put into evidence 127 pages of testimonials for Dr Rauniar in various forms including a patient satisfaction survey [A1/147-273].

Closing submissions and findings

74. The PCT made closing submissions in writing (21 pages) to which Dr Rauniar put in a detailed response (69 pages). We accept the obligation to consider the matters referred to in Regulation 5 of the Performers Regulations 2004 and we also accept that the effect of Dr Rauniar's performance on the efficiency of services provided by the PCT should be determined generally rather than by reference to a handful of individual cases alone.

75. There is no useful evidence about the selection of the fifty cases examined by Dr Ashworth and we have therefore proceeded on the assumption that they are typical of Dr Rauniar's caseload as a whole: we do not accept that there was an adverse selection by Ms Osman in order to prejudice the case against Dr Rauniar.

76. We further accept that Mr Ridout's evidence has limited value in the light of the date of his visit to the practice and also that the testimonial evidence and that of Mr Bangladesh show a high degree of support for Dr Rauniar from his patients. We have also taken into account the six letters from professional colleagues giving Dr Rauniar varying degrees of approval and accept that this material is relevant to the question of Dr Rauniar's efficiency.

77. We do not accept Dr Rauniar's criticisms of Dr Ashworth's experience or the general reliability of his evidence: Dr Ashworth struck us as extremely fair-minded and prepared to praise Dr Rauniar's practice as much as to make criticisms of it. Nor do we accept the validity of the comparison with Dr Healy in paragraph 14 of Dr Rauniar's submissions: Dr Healy, as is clear from the papers and proceedings as a whole, was performing a very different function on Dr Rauniar's behalf.

78. We now turn to the individual cases where the PCT still criticises Dr Rauniar's care.

79. Case 1: we take into account the grammatical and syntactical style of Dr Rauniar's record-keeping. We accept that the note "…and blood in urine" is unambiguous and reject the submission that the word "no" after "and" is missing in error. We accept the PCT's assertion that the letter "E" in the computer records does not mean that an examination took place. We do not accept that a history was taken or an examination performed to exclude a sexually transmitted disease. We reject Dr Rauniar's point that this is an allegation not before the PCT hearing – Dr Ashworth's report at [R1/54] clearly states "No investigations of underlying cause". That seems to us apt to include an allegation of failure to examine.

80. Our finding is that the patient did complain of haematuria on 10 May 2004 and that his complaint was not adequately investigated. Whatever the result of the dipstick test the patient should have been given a MSU test as indeed he was. Even though the MSU was negative, given the potential seriousness of the underlying causes of haematuria, we believe that further investigation by the doctor or a referral should have taken place.

81. Case 2: again we find that Dr Ashworth's written criticisms at [R1/54] are wide enough to permit an inquiry into Dr Rauniar's consultation with this patient on 7 June 2004. Indeed Dr Rauniar himself went into considerable detail to describe his examination of the patient. We find that such a detailed examination did not take place and that the patient should have been urgently referred to a vascular surgeon. We find that reliance on the prescription of Praxilene was an inadequate response to the patient's presenting symptoms. We note that the observation of Berger's Sign in an Afro-Caribbean patient would

have been difficult however dark his skin was. We do not regard Dr Rauniar's experience in vascular surgery was enough to render his conduct acceptable.

82. Case 4: we cannot accept that this is a new issue of fact. The appellant's conduct in prescribing Pioglitazone was criticised at the PCT hearing and at that hearing Dr Rauniar told the PCT panel that the patient was going to see his consultant in 2-3 days and that the patient had been given the prescription to take away but told not to "cash" it until he had seen his consultant [R1/86]. It is clear that the consultant appointment was some 5 weeks after Dr Rauniar saw him [R3/41] and [A4]. Dr Rauniar's evidence before us was that he had not given the prescription to the patient but had left it at the receptionist's desk as he commonly did. He accepted that he had made no record of this in the patient's records.

83. This unexplained contradiction raises grave concerns about Dr Rauniar's credibility. We find that the prescription itself was inappropriate and the record-keeping inadequate. We accept the PCT's submission that a computerised record of 8 weeks' prescription with a follow-up appointment in 8 weeks [R3/41] renders it probable that an instruction was not given not to begin taking the prescription until the patient had seen his consultant some 5 weeks later.

84. Case 5: whenever Dr Rauniar first introduced his justification of his treatment of this patient, it contradicts what he apparently told Dr Healy and Dr Healy's own view that the treatment was wrong. We do not accept that the article at [A5] is directly relevant since it deals with menorrhagia and not this patient's presenting problem of heavy bleeding after the menopause. We accept the collective view of the experts and Dr Rauniar's previous view that the treatment was wrong.

85. Case 9: we are unable to conclude that examinations were not performed on 16 and 29 December 2003. Consequently we accept that the prescription of oral salbutamol was appropriate but note the difficulty caused by the paucity of the records.

86. Case 11: we find that there was an inadequate recording of facts as conceded by Dr Rodger on Dr Rauniar's behalf at the PCT hearing [R1/82]. "Depression – not sleeping well" appears to us to be an inadequate record of the case.

87. Case 12: the reference at the PCT hearing to the retinal fundi not having been examined appears to us to raise an issue about the extent of the examination performed. We accept on the balance of probabilities and in the absence of any contrary record that an appropriately full neurological examination was not performed. We do not consider Dr Rauniar's neurological experience relieved him of the obligation to refer this patient to a neurologist. The absence of an adequate record has again influenced our findings. We do not accept that it is common or acceptable practice to have a policy of not recording negative findings.

88. Case 13: we accept that the questions of fact set out at 27.1 – 27.5 of the PCT's submissions are raised by the questions about diagnosis raised at the PCT

hearing. We accept that the reference to conjunctivitis in the notes for 14 August 2003 was Dr Rauniar's diagnosis rather than the patient's own description of her condition. Were it otherwise we would have expected it to have been made clear, for example by the use of inverted commas, and Dr Rauniar's own diagnosis to have been entered in the notes. On the basis of those findings we agree with Drs Ashworth and Healy that the prescription of steroid eye drops was inappropriate and that fluorescein should have been used.

89. Case 15: we accept that the patient's pulse rate had been 120 bpm but in December 2001, over two years before the consultation in question. We are satisfied that the quality of the examination arises out of the third point in Dr Ashworth's comment on this case [R1/56]. We are not persuaded that no examination was carried out although there is again inadequate recording of the consultation.

90. We accept the evidence of Drs Ashworth, Healy and Hogan that the prescription of oral salbutamol was inappropriate. We find that the record of the 20 January 2004 consultation was inadequate but do not regard the note "if chest pains, call ambulance" as unreasonable. We accept that the letter from the consultant querying the prescription before seeing the patient was indeed unusual and evidence of the serious error inherent in the prescription.

91. Complaint of Ms #: we have had the advantage of hearing oral evidence on this issue from Ms # as well as from Dr Rauniar. There is no doubt that Ms # is a forceful person with high (but reasonable) expectations of the medical profession. We accept, having heard both witnesses, that she did inform Dr Rauniar that she was suffering from bleeding piles and indeed that that was the main reason for her visit to the surgery. In the light of Dr Rauniar's record keeping we do not find the absence of a note about the piles in the records surprising or compelling. We accept that Ms # was taken aback, shocked and upset (as she described her emotions in evidence) rather than aggressive and threatening. It may well also have been that Dr Rauniar was upset by the consultation and, as it were, entered "his side of the story" in the notes by describing Ms # as "angry, aggressive and violent" [A1/60]. We observe that the note is uncharacteristically long and detailed.

92. We accept that confusion arose over Ms #'s evidence to the PCT hearing but prefer her account to that of Dr Rauniar. The charge of £5 for the pregnancy test is in contravention of NHS regulations and good practice that regard such a test as treatment for which a charge to registered patients is not allowed. More importantly we find that the failure to treat bleeding piles was unacceptable.

93. The PCT criticises Dr Rauniar's record-keeping. Whilst we accept that the evidence relating to the selection between manuscript and computerised records was highly confusing, we bear in mind that Dr Ashworth found much to commend in the standard and clarity of the records. We consider, however, that the quality was inconsistent and that a general policy of not recording examinations or negative findings is unacceptable in modern general practice.

94. The PCT criticises Dr Rauniar's response to complaints. We find that his attribution of all these to the malevolence of his former partner is unrealistic and evidence of a style and attitude that is out of place in modern general practice. We deprecate the following statements made by Dr Rauniar in his oral evidence and referred to in the PCT's submissions at paragraph 36:

(e) In relation to patients complaining about more than one symptom: "I have noticed in the past, they come for one thing and they talk about seven or eight things. I have got one brain. I haven't got seven brains to deal with seven problems. They ask absurd questions and I felt I am wasting time. To make sure they don't disturb me again, I tell them."

(f)"I would rather use my time for patients who appreciate me." and

(g) "She is repeating things from a previous letter as if I have no medical knowledge and am talking nonsense. I have to put a stop to this and be a little harsh."

95. In paragraph 78 of his submissions Dr Rauniar does not accept the accuracy of these statements but does not suggest how they are inaccurate. They accord with our recollection and record of the evidence and we accept that they accurately record the sense of that evidence.

96. We accept that at times when Dr Rauniar was giving evidence he was unwell and, indeed, adjournments were given without question at appropriate times. We do not, however, accept that this is an adequate explanation for his demeanour on 18 December 2006 (on which date he told us he was in satisfactory health) when in giving evidence he was intransigent, abrasive and unable to accept any criticism whatever either in relation to his clinical practice, his patient care skills or the inconsistencies in his evidence.

97. We cannot fail to be adversely affected by the explicit but, at best, disingenuous claim on his professional letterhead to be a Fellow of the Royal College of Surgeons. It is simply no answer to say (as is said in his closing submissions at paragraph 79) that any "misapprehension" is "clearly corrected" in Dr Rauniar's CV. The correction is a manuscript addition to a typescript CV that was faxed (presumably to his advisers) as late as 6 March 2006. We do not know when the manuscript addition was made but have seen in the papers before us the letterhead bearing the false claim as long ago as 2002. This has been a key factor in our hesitation to accept Dr Rauniar's evidence (when contested) as credible.

98. Dr Rauniar relies in his closing submissions on procedural unfairness in the PCT hearing in that his representative was not allowed to question Dr Ashworth or Ms # and cites R (Dr SS) v Knowsley NHS Trust [2006] Lloyds Law Rep Med 123 in support. We accept that good practice now requires the Chair of the hearing to give permission to question witnesses but note that the decision cited was made almost seven months after the PCT hearing and that that hearing followed what was then the practice recommended by the Department of Health. In any event Dr Rauniar has had the opportunity, represented by specialist

Counsel, to cross-examine these witnesses before us. We understand his submission to which, in the context of sequential written submissions, the PCT has had no opportunity to respond to be that Dr Rauniar's legitimate grievance at the unfairness explained the manner in which he gave his evidence.

99. We do not accept that anger with the PCT was an acceptable reason for the manner in which Dr Rauniar, as a professional person gave evidence to us and we do not accept that his evidence was "credible on key issues" as an overall approach to the case.

100. We take into account the testimonial evidence and accept that Dr Rauniar's care of his patients has satisfied many of those patients. We cannot, however, ignore the shortcomings identified above in relation to consultations, patient safety, prescribing, record keeping and his attitude to patients presenting with more than one complaint. In addition we are troubled both by his refusal to accept any criticism of his practice and (despite what is said on his behalf about provocation and his state of health) by his demeanour.

101. Far more importantly we regard his misleading claim to Fellowship of the Royal College of Surgeons both to be inexcusably inappropriate conduct and as raising the need for the greatest caution over acceptance of his evidence where there are factual disputes to be resolved.

102. We are not swayed by the argument that there is no proof of actual harm to any patient. We accept Dr Ashworth's evidence that Dr Rauniar's record on patient safety, judged on the basis of a sample of cases that we have no reason to believe unrepresentative, was well towards the "bad end" of the performance spectrum.

103. Our overall finding is that Dr Rauniar's continued inclusion on the PCT's Performers List would be prejudicial to the efficiency of the services in question.

<u>Contingent removal</u>

104. We can understand the PCT's submission that contingent removal would be a proportionate response in the light of the evidence referred to in paragraphs 72-73 above together with the satisfactory Patient Survey, PACT information, wide range of services provided, high quality of practice building and facilities and Quality and Outcomes Framework results and targets achieved referred to in paragraph 80 of Dr Rauniar's final submissions.

105. Under Regulation 15(3) of the National Health Service (Performers Lists) Regulations 2004 the FHSAA may make any decision that the PCT could have made. The Panel does not agree that the conditions currently imposed by the PCT should be maintained. Instead we decide that Dr Rauniar should be contingently removed from the PCT's Performers' List subject to the following conditions:

(a) he shall not from the date of this decision work in any capacity as a NHS General Practitioner except under the supervision of a workplace supervisor who shall be a GP trainer accredited by the London Deanery

and approved by Waltham Forest PCT and this condition shall remain in force until the expiry of six months from the date of any commencement of such work;

(b) he shall not during the period of supervised work under (a) above work for less than five sessions per week except in case of certificated absence through illness;

(c) he shall agree with the Director of Postgraduate General Practice Education, or his or her nominated deputy, a Personal Development Plan to address the deficiencies in his practice to include the following areas: interpersonal skills, communication skills and consultation skills and submit that Plan to the PCT within 2 months of the date of this determination;

(d) the supervisors referred to in (a) and (c) above shall submit two-monthly reports to the PCT concerning Dr Rauniar's work and personal development.

106. The Panel reminds the PCT of its obligations to Dr. Rauniar under Regulation 15 (4) of the 2004 Regulations.

107. We direct, pursuant to Rule 47(1) of the Family Health Services Appeal Authority (Procedure) Rules 2001 that a copy of this decision is sent to the Secretary of State, The National Assembly of Wales, the Scottish Executive, The Northern Ireland Executive and the Registrar of the General Medical Council.

108. Any party to these proceedings has the right to appeal this decision under and by virtue of Section 11 of the Tribunals and Inquiries Act 1992 by lodging notice in the Royal Courts of Justice, Strand, London WC2A 2LL within 28 days from the date of this decision.

……..
Mark Mildred
Chair of Appeal Panel
19 February 2007