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In the Family Health Services Appeal Authority case no: 13833

Heard at Napier House, 24 High Holborn, London	
On 24 & 25 January 2008	

Before

Mr J D Atkinson (Chairman)
Dr G Sharma
Miss K Wortham

Between

Dr RONALD BERGAUER
(GMC No. 6121762)

Appellant

and

NOTTINGHAM CITY PRIMARY CARE TRUST

Respondent

Representation:

For the Appellant: Mr J Counsell of Counsel
For the Respondent: Mr M Mylonas of Counsel

DECISION AND REASONS

The Appeal

1. This is an appeal by Dr Bergauer against the decision of the respondent dated 8 May 2007 to remove him from the respondent's medical performers list under the Health Services Act 1977 (as amended) and associated regulations.

The Background and Proceedings

2. The appellant was born on 2 April 1960 at Mazquit in Turkey. The appellant worked as a general medical practitioner in Austria from 1996 to 2005. The appellant came to the United Kingdom in 2005.

3. On 14 October 2005 the appellant was included on the respondent's supplementary medical performers list.

4. On 29 November 2005 the appellant was removed from the respondent's performers list as a

salaried GP.

5. On 30 November 2005 the appellant was included on the respondents medical performers list as a non principal locum subject to various conditions.

6. On 12 April 2006 the respondent varied the conditions of inclusion following complaints from a patient A.

7. On 5 October 2006 a GMC interim orders panel imposed conditions on GMC registration.

8. On 24 November 2006 the appellant, following an oral hearing, was suspended for 20 days from the respondent's performers list pending further investigation following complaints from patient C.

9. On 21 December 2006 and on various dates thereafter the respondent notified the appellant of extensions to the period of suspension.

10. On 19 March 2007 the respondent conducted a removal hearing attended by the appellant and Counsel. A decision was deferred pending a GMC hearing.

11. On 8 May 2007 the respondent made the decision against which appeal is now brought (respondents bundle R60). The respondent decided that the appellant should be removed from its performers list on the grounds of efficiency and unsuitability because of complaints received from the Nottingham and Darlington areas. The decision letter only generally referred to the evidence heard and did not make specific findings of fact.

12. The Panel note here that the respondents decision involved consideration of allegations relating to the appellant establishing an improper relationship with patients, dishonesty (not property related), abuse of a position of trust, inappropriate clinical and intimate examinations and poor clinical practice with regard to 4 patients A, B, C and D. The respondent also had regard to other incidents, but it is unclear what weight was attached to those matters.

13. On 1 June 2007 the appellant appealed to the Family Health Services Appeal Authority. Appeals to the FHSAA are by way of redetermination.

14. A more detailed chronology of events, as agreed by the parties, is set out in the appellant's bundle at A31.

The Law

15. The relevant law is to be found in the 1977 Health Services Act as amended together with associated regulations. Extracts of the relevant law as set out in The National Health Service (Performers Lists) Regulations 2004 as amended and may be summarised as follows:

> Regulation 10(3) and (4)… a primary care trust may remove a performer from its performers list where… 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…or where he is unsuitable to be included in that performers list

Preliminary matters

16. At the outset of the hearing Mr Counsell on behalf of the appellant produced a detailed skeleton argument and made further oral submissions. It is not necessary to set out the arguments in full here. In essence it was submitted that the appeal would not amount to a fair hearing if the written and hearsay evidence relied on by the respondent were to be

admitted in evidence to the Panel, and particularly so, given that the respondent would not be relying on oral evidence from the complainants. Thus, it was submitted, written witness statements from witnesses who were not to be called, hearsay, and evidence as to the investigation process must be excluded.

17. Mr Mylonas made a number of submissions in reply that may be summarized as follows. The Panel has discretion as to whether or not to admit the evidence. The respondent has put forward reasonable explanations as to why it is unable to call the complainants A-D to give oral evidence.

18. The Panel after due deliberation directed that the evidence on which the respondent wished to rely be admitted in evidence for the following reasons.

19. The Panel by virtue of regulation 41(6) of the Family Health Services Appeal Procedure Rules may receive evidence of any fact which appears to be relevant notwithstanding that such evidence would be inadmissible in proceedings before a court of law. In exercising this discretion the Panel were mindful that the burden of the proof rested with the respondent and in particular that the standard of proof to be applied is the civil standard, applied flexibly, that is to say that the more serious the allegation, the more cogent is the evidence required to prove it.

20. The Panel took the view that it was capable of meeting the concerns of the appellant by assessing the evidence and attaching appropriate weight to it, bearing in mind the seriousness of the allegations. The Panel concluded that admission of the disputed evidence would not give rise to an unfair hearing.

The documents and evidence considered

21. The appellant and respondent submitted documentation which was compiled into bundles marked A and R. A is paginated to A36 with further tabs a and b. Tab b contained the investigating officer report (IOR) numbered to 56. Bundle R is paginated to 113.

22. For the hearing the appellant also produced a supplementary bundle marked ‘defence bundle’, the details of which need not be set out here.

23. For the hearing Mr Counsell and Mr Mylonas produced skeleton arguments. A copy of the decision of Toulon J in the Knowsley case [2006] EWHC 26 (Admin) was also provided to the Panel.

24. In addition, in the course of the hearing the Panel gave leave to both parties to file further evidence which was compiled to into a further bundle C, comprising 11 pages, the details of which I need not set out here.

25. The Panel heard oral evidence on behalf of the respondent from Mr Don Gardner, the then practice manager at the Linden Medical Group Surgery and Miss Donna Staples, the then contractor performance and development manager for the respondent.

26. The Panel heard oral evidence from the appellant on his own behalf and from Gulhan Yildrim with whom the appellant has had a relationship.

Opening submissions on behalf of the Respondent

27. Mr Mylonas opening submissions may be summarized as follows. The respondent’s evidence is that the appellant was notified of allegations concerning 4 complainants A-D. An investigating officer, Donna Staples, was appointed to compile a report on the allegations.

28. The background to the allegations is that initial concerns were expressed about the appellant in September/October 2005 arising from his work as a locum at a surgery known as the St Albans practice in Nottingham. It is alleged that for example he made the staff and patients there feel uncomfortable and that he had approached young girls for dates. In consequence the appellant had been asked to leave the practice by Dr Randev, the clinical director.

29. The complaint of patient A arose from an incident on or about 9 March 2006 at the Parkgate surgery in Darlington. It is alleged that the appellant asked A inappropriate questions about her personal circumstances, and rang the appellant at home with a view to establishing an improper relationship and said that he was going to call at her home. It is alleged that the appellant denied the allegation of contacting patient A at home, and only accepted that he had done so when he realized that the call could be traced.

30. The complaint of patient B arises from a consultation on 22 September 2006 at the Linden Group medical practice in Nottingham. It is alleged that the complainant at consultation was made to feel uncomfortable by the appellant who kissed and held her hand and attempted to establish contact with her outside the confines of a doctor patient relationship.

31. The complaint of patient C arises from a consultation on 14 August 2006 at the Linden practice, but not reported until 19 October 2006 to the practice manager Mr D Gardner. The details of the allegations are set out in an unsigned witness statement at R76. The allegations are, that over a consultation period lasting 43 minutes, C was repeatedly touched inappropriately including on the head neck and ears, was subject to an inappropriate intimate examination of her breasts, was asked unnecessary questions about her sex life and invited to meet the appellant after he had finished work.

32. The complaint of patient D arises from a consultation of 8 August 2006 at the Linden practice. It Is alleged that she was made to feel uncomfortable by the appellant demonstrating the use of a stethoscope to D's son by placing the disk around her cleavage area.

Oral Evidence on behalf of the respondent

33. Mr Gardner in oral evidence adopted his statement of 28 September 2007 (R85) as evidence in chief. His further oral evidence may be summarized as follows. The Linden practice is large with a patient list of about 14,500 and 7 GPs. In the 14 years of his employment at the practice he had not come across complaints of inappropriate behaviour until those relating to the appellant. Mr Gardner was not asked any questions in cross examination.

34. Miss Staples in oral evidence confirmed that she was the author of investigating officers report (IOR). Relevant extracts of her further oral evidence may be summarized as follows. Miss Staples has experience of conducting investigations. In conducting an investigation her approach is to establish the facts and to obtain clarification of what people say in an unbiased way. Notes of interviews are taken to ensure accuracy. They are sent to the interviewees and all those present for their signatures as to accuracy.

35. At IOR 52 question 8 reference is made to the appellant's telephone contact with patient A. The word 'inappropriate' was used by the appellant to describe the proposed arrangement for his daughter who lives abroad to meet up with patient A's daughter . The appellant said that he rang patient A to say that their daughters could not meet, because the appellant's daughter was not going to be visiting him.

36. In cross examination Miss Staples said that the interview records were signed as to accuracy and to afford an opportunity for amendment. Miss Staples did not recall whether or not a signed record was received from the appellant.

37. Miss Staples accepted that within the body of the report, the record of interview summarized

the interview record. For example IOR 52, recording the appellant's replies at interview, were summarized in shortened form at IOR 14. IO52 records that the appellant later felt that the arrangements he had made for their daughters to meet, were inappropriate and telephoned patient A's home to say that the reason why their daughters could no longer meet was because his daughter was not coming to visit him.

38. In answer to questions from the Panel Miss Staples said that, as set out at IOR 13, the appellant saw patient C as the first patient on the afternoon list of 15 patients. The computer system records when a patient arrives in reception, the doctor pushes a button to record that the appellant has entered the consultation room; the doctor then presses a further button when the patient leaves. A printout of events is available showing the times in respect of patient C. The record shows that patient C had an appointment at 3.30; that she arrived at 3.31; that she went in to see the appellant at 3.32; and that she left at 4.14, making a total time of 42 minutes. The records show that all patients after that were running late.

Oral evidence on behalf of the appellant

39. The appellant gave evidence on his own behalf in English. The Panel records here that at times it was difficult at first to understand what the appellant said. However, the Panel are satisfied that throughout the proceedings Counsel took appropriate steps to ensure that the appellant understood the questions and that his replies were intelligible. The Panel gave guidance to the appellant about giving evidence audibly and ensured that questions put to him were appropriately paced. Counsel throughout the proceedings made no submissions to the effect that the appellant was put under a disadvantage by giving evidence in English.

40. At first the appellant had difficulty in understanding that he was being asked to confirm that the contents of his statement dated 26 November 2007 were accurate and that it was to be adopted as his evidence in chief. The appellant did however adopt his statement subject to amendment of a typographical error in paragraph 2 (substituting 20 October 2005 for 20 August 2005).

41. Extracts of the appellant's further oral evidence may be summarized as follows.

42. The document at C1 is a copy of patient A's handwritten note of her telephone number as given to the appellant at the consultation in March 2006. The patient gave her telephone number willingly.

43. As to patient C, the appellant had seen patient on an occasion prior to the consultation of 14 August 2006 that gave rise to the complaint. In that prior consultation, the patient had discussed issues relating to sex with her. It was in that context that the appellant at the following consultation on 14 August 2006, had discussed sexual matters with patient C.

44. In cross examination it was put to the appellant directly that he was a liar. The appellant said that he did not accept that.

45. The appellant was asked about the reasons why he rang patient A and in particular why he had said, as indicated at IOR 52 question 8, that he felt that the arrangements for their respective daughters to meet were inappropriate and that his girlfriend had encouraged him to phone patient A and say that his daughter was not coming. In reply the appellant said that he had not used the word inappropriate at interview and that he had not approved the record of his interview with Miss Staples. The appellant accepted that he had seen the record but could not recall whether or not he had discussed it with his representative.

46. The respondent was then shown a letter, (C10), dated 3 January 2007 from his medical protection society representative, Dr Stacey, to Miss Staples indicating that following discussions the appellant was content with the note of the interview meeting. The appellant

said that he did not agree with the record and did not recall telling Dr Stacey that he did agree.

47. The appellant was asked about the circumstances in which he left the St Albans practice of which Dr Randev is the clinical director. The appellant said that he had left because he and a number of other doctors had not been able to form a good relationship with the staff there. He denied that he had been asked to leave because of his behaviour. The appellant was asked if that were the case why Dr Randev had written to him on 20 October 2006 asking him not to attend at the St Albans practice. The appellant said that he and Dr Randev had not had a good relationship and that there was a problem with other doctors at the practice and the nurses. When asked specifically what the problems with the nurses were the appellant said he could not be specific and that he was not a liar.

48. The appellant was asked about the circumstances in which he had called patient A on 10 March 2006, as set out at IOR 24-25. It was put to the appellant that at about 4.15 pm he phoned patient A's house, which the practice secretary reported to the PCT at 4.45 pm,, and that the appellant denied making such a call on 2 occasions shortly thereafter, first to Sue Goulding and then on interview with Sue Goulding and Dr Dixon at around 6.00pm the same day. The appellant said that as he did not know who Sue Goulding was when she rang, so he did not answer the questions she put to him. The appellant said that he had been very stressed because of an aggressive patient and so he had denied making the call and did not recognize the name of the patient. However, in the evening he had spoken to his medical protection adviser and asked him to write saying that the appellant had made the call.

49. The appellant was asked why after he had admitted making the telephone call he had said that the complainant had been motivated by racism or because she did not like the appellant. The appellant said that that remark was in relation to racism generally in Europe, and not about the complainant. In addition, at the interview with Dr Dixon, Dr Dixon had not appeared friendly and therefore the appellant had not trusted him.

50. The appellant was asked about the consultation with patient C. The appellant said that he would expect a consultation of the sort carried out on patient C to take about 15 minutes, and certainly less than the 42 minutes recorded. The computer recording system is such that if the doctor does not push the button L to record that a patient has left, there is an automatic reminder and also the need to double click when calling for the next patient. The appellant did not recall the length of time taken with patient C because of the passage of time since those events. It may be that the appellant was doing paperwork between the end of the consultation with C and seeing the next patient; for example in relation to home visits undertaken earlier in the day.

51. In re-examination the appellant said that he had been under stress when interviewed by Dr Dixon about patient A. The appellant had had to deal with an aggressive patient earlier in the day and Dr Dixon had not been friendly. Dr Dixon had told the appellant that his medical life was finished. The appellant could not recall if he had been doing paper work following the consultation with patient C, but he may have been doing so.

52. Ms Yildrim also gave oral evidence on behalf of the appellant. She adopted as evidence in chief her statement dated 15 March 2007. In brief her evidence is that she recalls a conversation in which she told that appellant that he should ring a patent as a matter of courtesy to cancel arrangements for their respective daughters to meet up because the appellant's daughter was no longer coming to visit him in the UK. Ms Yildrim was not subject to any further significant questioning.

The Respondent's closing submissions

53. Mr Mylonas, on behalf of the respondent, made a number of submissions which may be

summarized as follows. The main ground of the respondents case is that the appellant is unsuitable because of grave breaches in his duty as a doctor to his patients and that he should be removed from the list. Little significance is now attached to the ground for removal based on his efficiency.

54. The evidence of complaints comes from a number of witnesses who are all unrelated. Patient C has given reasons why she would not attend to give oral evidence. Patient A has indicated that she did not wish to attend. It is for the Panel to weigh the evidence and come to its own view.

55. The evidence shows the appellant to be opportunistic, dishonest and unreliable.

56. In respect of patient A, on the appellant's own evidence he has been shown to have lied on 2 occasions about a telephone call to her home. In giving his account of events the appellant has attempted to suggest that the complaint was motivated by racism or personal animosity and that he had not admitted to making the call because he felt intimidated. In oral evidence the appellant also suggested that he had not agreed the record of interview with Miss Staples, yet there is a letter from his medical protection adviser dated 3 January 2007(C10), indicating that he had discussed the note with the appellant who would return it signed shortly.

57. The appellant had also lied about the length of time of the consultation with patient C. Patient C's account was detailed and incidentally supported by remarks over heard from another patient who had complained about having to wait to be seen. The appellant had not given a logical explanation as to how he had occupied his time in such a lengthy consultation.

58. In summary in these circumstances the respondent was not able to trust the appellant. There were 4 victims. If their evidence was not believed it would set a dangerous precedent that would have the effect of putting off people from complaining. In addition the appellant on his own account had shown himself to be dishonest.

The Appellant's closing submissions

59. Mr Counsell, on behalf of the appellant, relied on his skeleton argument and made a number of further submissions that may be summarized as follows.

60. In the absence of oral evidence it was impossible to assess how much weight should be attached to the evidence and no specific allegations from the patients had been put directly to the appellant at this hearing.

61. The respondent now relied on peripheral matters related to allegations of the appellant lying. If the Panel were minded to find that the appellant was lying, then consideration should be given to the established principle that in assessing charges against a defendant, there may be many reasons why a person does not tell the truth, and as such, the lies do not establish the truth of the events complained of took place (a **Lucas** direction).

62. It is accepted that in oral evidence the appellant was not always easy to understand. It is accepted that the appellant may be thought to have a disconcerting manner. However, this may well provide the explanation for differences in the record and misunderstandings revealed in the records of events.

63. The evidence of patient C is set out in an unsigned statement which, given that the appellant's account of events have not been put to her, gives rise to doubts about its reliability.

64. It had been suggested that the appellant has acted inappropriately in relation to patient A.

However, it has not been explained why the appellant's making of arrangements for his daughter and patient A' daughter to meet is inappropriate. The allegation that the appellant was going to call at patients A's house is a misunderstanding that would typically arise given the appellant's communication skills.

65. In respect of patient B, the incident complained of was made anonymously and was not seen as so significant as to warrant a formal complaint. In the absence of oral evidence it would be unsafe to rely on the written evidence.

66. In respect of patient D who complains of being made to feel uncomfortable by the appellant, it is not possible to rely on her account in the absence of her being questioned about her recollection of events. The appellant in any event has no recollection of the consultation given that the consultation is said to have taken place 2 months prior to the matter being brought to his notice.

67. The remainder of the evidence is of little significance and in the issues in themselves would not have been likely to lead to suspension from the list.

68. In summary, the respondent has failed to discharge the burden of proof to the required standard in showing that the appellant is unsuitable.

Assessment of Evidence and Findings of Fact

69. The Panel considered all the evidence, the submissions of the representatives, and makes the following findings.

70. The Panel first turns to the respondent's case based on allegations which maybe loosely termed as relating to issues of sexual impropriety such as inappropriate touching or examination. The Panel finds that the evidence is not sufficiently cogent as to make findings against the appellant to the requisite civil standard of proof for the following reasons.

71. The main evidence in this respect is from patient C. For reasons explained and, set out at documents C7-8, patient C has chosen not to give oral evidence because of her fear of being upset and the possible detrimental effect giving evidence might have on her. That means her account cannot be tested by cross examination and the appellants account put to her directly.

72. In the absence of oral evidence from patient C, the respondent relies on a written statement from her as set out at R76-79. However, that statement has not been signed by the witness. In the absence of a signature showing positive affirmation of the truth and accuracy of that statement, the Panel has doubts about the extent to which it can be truly said to reflect the witness's evidence. It may be that the witness would wish to correct or amend certain aspects. The respondent has adduced evidence as to how the statement was compiled. However, the Panel finds that given the seriousness of the allegations, the unsigned statement of patient C is not sufficiently cogent to prove those allegations. That does not mean that the statement carries no weight whatsoever, but simply that in respect of the allegations of sexual impropriety, even when taken together with all the other evidence, it is not sufficiently cogent.

73. The same can be said of the allegations of sexual impropriety arising from the complaints of patients A, B and D.

74. Patient A has, for a variety of reasons, not given oral evidence. There is no written statement from her as to the events that took place at the consultation. Patient A was not interviewed by the investigating officer Donna Staples. These are significant factors that suggest a lack of

sufficient cogency.

75. Similarly, there are no formal written statements from patients patient B and D.

76. Thus taking together all the evidence, so far as it relates to the specific events and allegations of sexual impropriety, the Panel finds that the evidence relating to such matters is not sufficiently cogent.

77. The Panel however, now turns to the respondent's case so far as it relates to what has been termed the appellant's dishonesty, opportunism and unreliability which are said to be a further basis for finding him unsuitable to continue on the list. There are a number of threads to this aspect of the respondents case and in respect of which the Panel makes the following findings.

Findings in respect of patient A

78. The Panel finds the evidence is sufficiently cogent to find that the appellant made a telephone call to the house of patient A, that on subsequent inquiry thereafter he denied making such a call on 2 separate occasions, and that he has not advanced a plausible explanation for his failure to tell the truth.

79. In respect of this telephone call, the evidence shows that the sequence of events is as follows. The appellant rang patient A's home on 10 March 2006 at 4.15. At 4.45 a secretary from the medical practice rang the Darlington PCT saying that a patient had expressed concerns about the appellant. Between 4.45 and 6.00 the same day Sue Goulding, the clinical governance manager at the PCT, rang the appellant about the allegations. The appellant at that time denied making a telephone call to patient A's home. Sue Goulding made arrangements for the appellant to meet with her and Dr Dixon, the medical director of the PCT, at the surgery at 6.00pm the same day to discuss the allegations. In the course of the interview, the appellant denied making the telephone call. The appellant subsequently contacted a representative from the Medical Protection Society and instructed him to write to the respondent accepting that the appellant had made the call.

80. The appellant's explanation for his repeated denial of making the telephone call is variously that: he did not remember the call because he was stressed, that he did not recognize the name of the patient, that he did not know who Sue Goulding was, and that Dr Dixon was unfriendly.

81. The Panel does not find these explanations to be satisfactory.

82. Thus it may well be that the appellant was feeling stressed when asked about the telephone call, however given that he was being asked about a telephone conversation that he had made at the most between half an hour and an hour and ¾ hours beforehand and, atypically a call to a patient on non clinical issues, it is highly unlikely that stress would result in such short term memory loss.

83. Similarly, the Panel does not accept that the appellant would not recognize the name of person in respect of whom he had only recently been making arrangements about their children meeting up.

84. Again, it is unclear why the appellant should be reluctant to speak to an officer of the PCT about a telephone call he had only recently made.

85. In addition, the appellant would have had a period of time, between the call from Sue Goulding and the meeting with her and Dr Dixon at the surgery, to reflect on the telephone call and to collect himself.

86. In those circumstances it is not accepted that the appellant, despite combination of all his claimed reasons, has advanced good reasons for denying on two occasions that he made the telephone call to patient A's home.

87. The Panel further note that in the course of these proceedings, the appellant for the first time suggested that a further reason for denying making the telephone call is because Dr Dixon was unfriendly at interview. That is an allegation that was not made to Miss Staples in the course of her investigation and was only elaborated on under cross examination. The appellant's failure to mention it an earlier stage is a matter that tends to undermine his credibility.

88. The Panel also finds the appellant's account of events leading up to the telephone call with patient A to be inconsistent. The appellant in his witness statement at A25 paragraph 8 states that his partner said that he should call patient A as a matter of courtesy because the appellant had learnt that his daughter was no longer planning to come and see him and therefore would not be able to meet up with patient A's daughter. However, the record of interview with Donna Staples at IOR 52 shows that the appellant stated that he had felt the arrangements for the daughters to meet were inappropriate and that his girlfriend had encouraged him to ring patient A and say that the appellant's daughter was no longer coming to visit.

89. When this discrepancy was put to the appellant, he said that the record of interview was inaccurate, that he had never used the word inappropriate and that he had not approved the record.

90. The Panel finds this aspect of the appellant's account compounds the inconsistency of his account because, the evidence, in the form of a letter from the appellant's adviser at C10, shows that the appellant told his medical protection adviser that he was content with the investigation meeting note. The Panel finds that these are further matters that undermine the appellant's credibility.

91. The Panel finds that the credibility of the appellant is further damaged by his statements given in response to questions about why patient A might have made allegations against him. The appellant is said by Sue Goulding to have said that it may be due to racism on the part of patient A or because she did not like him. These are suggestions by the appellant that are wholly at odds with the context of his own account of the events relating to that telephone call. The appellant claims on the one hand that patient A agreed to contact with the appellant outside the confines of a consultation, and agreed that their daughters should meet up, yet on the other hand suggests that patient A was racist or did not like him. The appellant's explanation for these 2 contradictory positions is that he was only making general points about racism and his comments were not specifically about patient A. The Panel finds that explanation to be not credible given that the Appellant was being asked specifically about patient A, and his credibility is thereby further undermined.

Findings in respect of patient C

92. The Panel finds that there is sufficiently cogent evidence to show that the appellant has attempted to deliberately mislead in respect of the time taken in his consultation with patient C.

93. The evidence of the computer records show that the consultation with patient C lasted 42 minutes. This evidence is supported in the unsigned statement of patient C, leaving aside her own account of the consultation itself, by her remarking (paragraph 18) that when she left the consultation another patient was complaining about having to wait over an hour for her

appointment. This remark is also consistent with the computer records showing that all the remaining patients in that afternoons list also ran late.

94. The Panel finds that the appellant's account of the length of time of the consultation to be evasive and implausible.

95. It was put to the appellant that the consultation had lasted 42 minutes and that he had said it lasted 10 to 15 minutes. The appellant's reply was that he had not said 10 minutes or 11 minutes or 15 minutes.

96. The Panel finds the appellant's further replies in cross examination to be evasive in that, for example, when asked further about the time of the consultation he said consultations can last 5, 20 , 25, 70 minutes. When asked further why he had told Miss Staples, as recorded at IOR 53, that the consultation would probably have taken about 10-15 minutes, the appellant said that he was only talking generally and that he did not know how long the consultation lasted.

97. It was put to the appellant that on his own account that the consultation had lasted 10-15 minutes, and that if that were the case what was his explanation for what had happened in the subsequent 30 minutes. The appellant said that it could be that he was doing paperwork arising from earlier home visits. The Panel finds that explanation to be wholly implausible. Patient C was the first patient in the afternoon list. The appellant knew that there were 15 patients in the list to see. The appellant would see from the computer screen that the second patient in the list was due at 3.40pm and actually arrived at 3.45pm. The Panel cannot see any circumstances where a properly trained and competent doctor would choose to do paperwork for up to half an hour when they knew that there were patients in the surgery with appointments waiting to be seen.

98. The Panel finds that the evidence shows that the consultation lasted 42 minutes and that the appellant has not only failed to provide a satisfactory account of how he spent those 42 minutes, but in giving his evidence he has also sought to give a misleading account.

Findings in respect of events at the St Albans Practice

99. There is a dispute as to the circumstances in which the appellant left the St Albans surgery. The appellant's position is that he left the practice freely of his own will, the respondents position is that he was asked to leave the practice.

100.The appellant in his written statement did not set out the reasons in any detail as to why he left the practice, but said that no concerns were raised with him at the time he was at the practice. In oral evidence the appellant said that he left the St Albans surgery because there was not a good relationship between him and the staff there, and that such difficulties were common to other doctors working there. The appellant was unable to give any specific examples of the poor relationship between him and for example the nurses at the practice.

101. The respondents position is that there were a series of allegations about the appellant's behaviour, which are summarised in the appellant's statement, and that the appellant was instructed in a letter dated 20 October 2005 from Dr Randev, clinical director at the practice, that following a conversation with the appellant, the appellant with immediate effect was no longer to have access to the premises (at IOR43).

102. The appellant was asked why Dr Randev would have written in those terms if, as claimed the appellant were simply leaving the practice of his own volition. The appellant said it was because of the bad relationship between the staff at the practice.

103.The Panel does not find that to be a satisfactory answer. The appellant was unable to be specific about the ways in which the relationship with Dr Randev or the nurses were said to

be *not good*. The evidence at IOR43 shows that Dr Randev made a positive decision to ban the appellant from the practice. There is no evidence, other than the appellant's account, to support the allegation Dr Randev was acting peremptorily because he and the appellant simply did not have a good relationship.

104. The Panel finds that the appellant was effectively dismissed from the practice by Dr Randev by letter dated 20 October 2005 and that the appellant has attempted to protect his position by writing a letter of resignation with effect from 21 October 2005 which is intended to mislead a casual reader of the documents in to a false reading of events.

Decision and Reasons

105. Looking at the evidence as a whole and in the context of the criteria for removal from the performers list and in the light of the above findings, the Panel directs that the appellant be removed from the respondent's performers list because he is unsuitable for the following reasons.

106. The appellant has failed to give a satisfactory explanation for failing to tell the truth on 2 occasions about making a telephone call to patient A's house. In trying to justify such failures the appellant has given inconsistent and implausible evidence and made a wholly unsubstantiated allegation that the person making the allegation against him was racist.

107. The appellant has given an implausible and evasive account of the time taken in respect of the consultation with patient C to the extent that his evidence amounts to a misleading account of those circumstances.

108. The appellant has attempted to give a misleading account of the circumstances that led to his effective dismissal from the St Albans practice.

109. The Panel finds that these behaviours show the appellant cannot be trusted to give a true and proper account of events; that he has demonstrated no powers of reflection, which are a fundamental feature of professional practice; and that he has a tendency to blame others for his own failings and as such does not take responsibility for his own actions.

110. When taken together these features show that the appellant has a deep seated attitudinal problem and demonstrate a persistent lack of insight into his actions. The Panel are of the view that such attitudes and lack of insight are fundamentally incompatible with practicing as a general practitioner and thus that the appellant is unsuitable to remain on the performers list. These characteristics are not amenable to meaningful change, at least to the extent that it could be said that the appellant is suitable to remain on the list.

Summary

The Panel directs that Dr Bergauer is removed from the Nottingham Primary Care Trust performers list on the grounds that he is unsuitable to be included in the list.

In accordance with Rule 42 (5) of the Rules the Panel hereby gives notice that a party to these proceedings 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 of receipt of this decision.

Signed Date

Mr J D Atkinson, Chairman