IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY Case: 13231

Mr. Paul Kelly Chair
Dr. S. Sharma Professional Member
Mrs. M. Frankel Member

BETWEEN:

DR JAYANTI KUMAR GHOSH

Appellant

and

NORTHUMBERLAND CARE TRUST

Respondent

DECISION WITH REASONS

1. This is an appeal by Dr. Jayanti Kumar Ghosh (GMC Regn. 0938051) (Dr. Ghosh) against a decision of Northumberland Care Trust (PCT) to remove him from its Performers List following a local hearing held between 4-6th July 2006 – a decision communicated to him by letter dated 12th July 2006.

2. Dr. Ghosh appears through Neil Garnham Q.C instructed by Nick Rawson of Messrs. RadcliffesLeBrasseur and the PCT through James Watson Q.C. instructed by Gerard McEvilly of Messrs. Hempsons. The hearing took place on the working days between 21st - 30th May.

3. The PCT removed Dr. Ghosh from the Performers List based upon "an efficiency case" Reg.10 (4)(a) The National Health Service (Performers Lists) Regulations 2004 (the Regulations) and "an unsuitability case" Reg.10 4(c) of the Regulations. Appeals are by way of redetermination and the FHSAA may make any decision which the PCT could have made.

4. The PCT case on efficiency is based on identified shortcomings (both individual and cumulative) revealed by the treatment of 4 patients A-D. Unsuitability is alleged on the basis of Dr. Ghosh's recruitment practices and relationships with his professional and non-professional staff over a protracted period. Both aspects of the case – but particularly the inefficiency allegations are supported by evidence relating to GMC proceedings and findings. The unsuitability case is supported by an Employment Tribunal finding adverse to Dr. Ghosh.

5. Directions required mutual service of witness statements within specified time limits. As a preliminary matter the Respondent applied for leave to extend time to enable a late witness

to be relied called. The witness is Joan Armitage, a former employee of Dr. Ghosh. Initially it was believed she could not attend the hearing so her statement remained unsigned. A late change in circumstances permits her to attend. Dr. Ghosh objected to evidence from the witness being heard. After hearing the submissions the panel extended time to enable Joan Armitage's statement to be received and oral evidence taken on the basis:-

the appellant had always been aware of the contents of the statement because it was used as part of the case against him at the local hearing;

there was no new material in the statement or in the evidence to be given by Mrs. Armitage;

inadvertent hearsay or other arguably inadmissible content could be safely dealt with by careful editing at the time she gave oral evidence;

there was no unfairness or prejudice to Dr. Ghosh who would have time before Mrs. Armitage gave evidence to deal with issues raised by her to which he may not previously have given attention;

part of Dr. Ghosh's case is contained in statements - themselves filed out of time;

the evidence would be useful to the Panel.

6. It was agreed the burden lay on the PCT to justify removal from its Performers List. The standard to be applied is the civil standard recognising that the more serious the allegation the less likely it is to have occurred and the more cogent and compelling the evidence required if it is to be proved

7. Although not bound by labels of 'efficiency' or 'unsuitability' used by the PCT to compartmentalise specific allegations we shall at this stage follow that order for convenience.

Efficiency

8. Particular allegations relate to deficient record keeping; inappropriate/insufficient patient care; inadequate attention to patient details and inadequate/unnecessary PSA testing within the practice.

9 On issues broadly described as patient care the PCT commissioned a report from John Unsworth the Clinical Director (Nursing) of the PCT. Dr. Unsworth is a PhD and unquestionably distinguished within his nursing speciality but with limited exposure to the rigours of general practice beyond early career experience as a community nurse, district nurse training and development of the nursing aspects of general practice. We have heard evidence from Dr. Unsworth and (called by Dr. Ghosh) from Dr. Martin Shutkever – a full time NHS GP principal of some years standing. A G.P trainer since 1991, a recognised 'Single Joint Expert' by the Law Society who has given expert evidence on G.P. matters at the GMC and elsewhere. He is able to qualify his evidence by including the usual statement recognising his duties to the decision maker rather than, in this case, to Dr. Ghosh. Dr. Shutkever's experience puts him in a better position to comment on the management of patients within a busy practice and where there is a dispute of fact between evidence from the two we lean in favour of Dr Shutkever's opinion.

10 (i) Patient A presented to the practice for the first time on the 23rd May 2003 for a minor ailment. There was no new patient check – a GMC Good Practice requirement. He was next seen by a locum on 3rd December 2003. Blood tests were done showing Hb of 6.7 and a low serum albumin. A letter was sent on 17th December asking him to see Dr. Ghosh. A consultation took place on 30th December in which it was recorded that the patient did not want to go to hospital. Further blood tests and monitoring took place 5th January 2004, 7th

January, 16th January, 20th January, 21st January and 26th January during which time the patient was prescribed iron tablets. The period revealed a slight initial improvement in Hb values. The last recorded consultation on the 26th January showed the patient's general condition as poor. Dr. Ghosh referred the patient for gastroscopy and haematology opinion.

(ii) It is worth mentioning at this stage Dr. Ghosh was suspended from practice between 7th August 2003 and December 2003

(iii) The PCT finds in part that Dr Ghosh failed to order further blood tests or arrange for the patient to have upper and lower G.I investigations when seen on 30th December. This is an error of fact. Dr. Ghosh did order such tests as the remarks on the notes 'Review for Hb' indicate.

(iv) We agree with Dr. Shutkever for Dr. Ghosh that the overall outcome of appropriate referrals within a month was reasonable but general management would have been improved by:-

better note keeping, in particular noting exactly the nature of discussions on 30 December when the patient indicated he did not want to go to hospital;

a general examination to assess the cardiovascular system and chest and abdominal palpatation to look for masses or enlarged organs;

a documented plan for further blood tests;

subject to the patient's views he could have been referred on the first occasion;

the referral letter should have been more inclusive, comprehensive and accurate reflected by the Consultant Haematologist requesting further information.

11 i) Patient B was hypertensive and seen by the practice nurse on 17th February 2004 for a routine cardiovascular check. Nurse Hunter also took blood for PSA. Although NICE guidelines do not recommend opportunistic PSA testing, we have clear evidence from Nurse Hunter this was common practice as part of a "well man" clinic. Notes in March by Nurse Hunter reveal a PSA level of 10 – abnormal. It is her evidence that she attempted to tell Dr. Ghosh of the reading and persuade him to see the Patient. Dr. Ghosh is claimed to have refused saying something to the effect that telling the patient – known as a friend of the surgery - might upset him. Dr. Ghosh denies that conversation took place or knowledge of the high reading. We shall return to the issue of communication and relationships within the practice but we are satisfied on balance that Nurse Hunter did attempt to tell Dr. Ghosh of the abnormal results. We are fortified in that view by Nurse Hunter's entry on the EMIS computerised record made on the 2nd March, made in capitals for the purpose of emphasis, to the effect that the matter had been referred to Dr. Ghosh to see the patient but that there was to be no follow up letter from the nurse.

(ii) It follows from our finding that Nurse Hunter did tell Dr. Ghosh of the abnormal reading that he had a responsibility to act upon it by, as a minimum, arranging a discussion with the patient which should have included an offer to refer to a specialist. He failed to do so.

12 Patient C had routine PSA screening as part of a well man clinic on the 3 September 2004. Results of the test do not appear on the patient's notes. There is no indication Dr. Ghosh saw the results or was informed of them. A note appears in November 2005 (by which time Dr. Ghosh was suspended) mentioning a level of 4.8 but it is unclear whether this refers to the September '04 test or one taken later. We make no findings adverse to Dr. Ghosh in connection with clinical care but again we shall return to issues of practice systems, communication and management.

13 Patient D had a routine PSA taken on 6th December 2004 by the practice nurse. A result of 4.3 (uncertain significance) was entered on the computer record but not the hand-written notes. On the 21st December the same nurse noted she had discussed the results with the patient and offered dietary advice. Dr. Ghosh saw the patient on 24th January 2005 for a shoulder injury. The criticism (with which we agree) is that Dr. Ghosh did not undertake an assessment of urinary symptoms or digital rectal examination on 24th January. He says he did discuss the PSA result with the patient on the 24th but the patient opted for monitoring through further blood tests at the surgery, which in the event was done. This advice is not recorded in the notes.

14 i) Bondicar Surgery became a single-handed practice on 31st July 2003 following the departure of Dr. Mcollum. It appears the well man clinic was in existence at that time but it is not clear by whom it was instigated or who directed what should be undertaken and when. What is plain is that routine PSA testing in otherwise asymptomatic patients was carried out by practice nurses. Nurse Hunter who has given evidence is even today blissfully unaware that guidelines do not recommend routine testing. At least 103 patients had PSA testing but it is not clear over what period or which were routine and which had symptomology. The fact that routine testing was done at all was contrary to good practice. It is no defence or mitigation for Dr. Ghosh to say, as he does, that routine testing was carried out without his knowledge. He must have known, from seeing notes at least, that testing was carried out and if he did not know that this was going on in his practice, he should have. Routine testing was clearly inefficient use of NHS time and resources.

(ii) Management of PSA results for patients B, C & D should have been carried out within the terms of a practice protocol introduced in January 2004 following intervention by Dr Brown, PCT Clinical Lead. It is clear that supervision of the protocol was insufficiently robust and inadequately monitored for it to brought the results in those cases to the attention of Dr. Ghosh. We believe Nurse Hunter when she says that the protocol, once written down, was seldom later referred to. This points to demonstrable inefficiency in management systems, again the responsibility of Dr. Ghosh.

15 In coming to its local decision the PCT rightly had regard to proceedings against Dr. Ghosh at the GMC commencing with a decision in March 2002. We are unaffected by and disregard the nature of the original complaints but are mindful of the conditions imposed on that occasion and renewed either wholly or in part in April 2005. Conditions relate in part to record keeping, history taking and examination of patients and require monitoring by the PCT whose Clinical Lead has been required to complete at least one comprehensive report for consideration by the GMC. In looking at 'efficiency' we are mindful of the considerable local resources required to monitor those conditions and the fact that since imposed in 2002, whilst not being breached, the conditions have failed to bring about the improvement in performance intended and which might have been fairly expected. Evidence relating to inadequate note taking in respect of patients A and D are but two current examples.

Unsuitability

16 The PCT case on unsuitability turns upon allegations that Dr. Ghosh pursued a policy of recruiting young, attractive and vulnerable women, mostly patients, as practice staff; that he used his professional position to establish or pursue improper emotional relationships with them; that he bullied, harassed and treated staff unfairly by giving preferential treatment to some and excluding, ignoring, intimidating or humiliating others and that he behaved improperly/unprofessionally with an emphasis on inappropriate comments and conversations. These are serious allegations requiring correspondingly cogent evidence.

17 There is no express or implied restriction on G.P.'s employing patients. Indeed Dr. Shutkever who gave evidence about other aspects of the case confirmed his practice (in a similar former heavily industrialised/deprived area to that of Dr. Ghosh's) employed some patients as staff. He does however recognise it can give rise to conflicts which would have to be properly dealt with as they arose. His is a multi-handed practice and it is more likely problems will occur in a single-handed practice. The overriding principle toward patients is covered by para.20 of the GMC Good Medical Practice which emphasises the need not to allow personal relationships to undermine the trust which patients have in their doctor.

18 Dr. Ghosh's account of his recruitment policy is that he would advertise in the local paper or, sometimes make enquiries of those who had previously expressed an interest in working within the practice. Some staff were patients others were not. He certainly did not pursue a policy of recruiting young, attractive and vulnerable patients.

19 There is some force in Dr. Ghosh's evidence. Of the witnesses called to give evidence, Linda Farrell had been on Dr. Ghosh's list but was not at the time of her appointment. We have seen copy advertisements in the local press or invoices for such for a period between August 2001 and October 2004 showing at least some attempt to recruit staff openly. Against that there are examples of recruitment that seemed almost coincidental, such as the approach to Joan Armitage (with no experience of reception work) who was asked if she wanted work when she attended the surgery with her son. Contrary to Dr. Ghosh's evidence that "I always took up references but sometimes they came as testimonials……" she was not asked for nor provided references. Likewise bumping into Linda Fawkes in the street with her mother and there inviting her for an interview. Linda Farrell, with no experience of office work being interviewed by Dr. Ghosh in 1998 before being appointed and soon elevated to a more senior position with no training.

20 We are bound to say the recruitment policy does raise suspicions but we cannot infer from the evidence at large that Dr. Ghosh purposely recruited young attractive and vulnerable patients as staff so he could exercise some sort of control over them. One needs look no further than Nurse Hunter – a formidable but conscientious lady- in no sense vulnerable. Of course she could be an exception in that Dr. Ghosh inherited her as Practice Nurse after the practice split in 2003 but she exemplifies the fact not all staff were of the type contended for by the PCT. Inferences other than that raised by the PCT can be drawn from the recruitment policy as we see it. Blyth is a deprived area and unemployment is high. Dr. Ghosh, consciously or otherwise, thought he could employ inexperienced staff for less money or he might have thought younger staff with less experience would be less likely to cause problems in the workplace or he wanted to be seen as a benevolent local figure. In short there are reasons other than the one contended for why the recruitment policy (if policy it be) is as it was.

21 Staff issues following appointment are another matter. There appears no structured in house or external training for novice staff. Training such as it was involved looking over the shoulder of more experienced staff. Particular aspects of Linda Farrell's employment are concerning. He employed her without previous work related skills; within two months had promoted her to public/patient relations; given her a pay rise; made unwanted offers of generosity toward her and her family and for practical purposes favoured her. The incident where she went with Dr. Ghosh to an evening meeting as she believed it, but which she says turned out to be a formal dinner has clearly left a marked impression on her. She felt completely out of her depth and her distress has taken her evidence to a point where we are not entirely sure of the exact nature of the event, a black tie dinner as she says or a more informal occasion comprising a talk on stress at work as Dr. Ghosh says. We are satisfied however Dr Ghosh showed favouritism toward Linda Farrell and then, when new staff joined – Wendy Keenan and Margaret Nesbitt, he took her off frontline duties and gave her minor tasks. Finally she took sick leave suffering stress and eventually left the practice. Although some aspects of Linda Farrell's evidence was unconvincing we are

persuaded of Dr. Ghosh's sudden ambivalence toward her by the content of a letter concerning redundancy sent to all staff dated 14 August 2000 in which he made specific reference to staff then off work with anxiety which he described as a mental illness being "naturally….not suitable to work in this practice." So far as we know Linda Farrell was the only staff member who was then off sick with stress. A similar inference can be drawn from the contents of a letter dated 28th January 2005 sent by Dr. Ghosh to staff requiring them to register with another doctor. It seems the demand that unless it was done by a certain date the staff member involved would be dismissed is unnecessary and authoritarian and quite inconsistent with the terminal paragraph thanking staff for their hard work and loyalty. The tone of correspondence points to an erratic, abrupt and aggressive style of staff management.

22 Whilst considering letters from the practice we notice that the notepaper heading frequently contains reference to a number of staff members with different titles i.e. Practice Nurse Clinician, Practice Manager, Assistant Practice Manager, Clinical Manager, Practice Secretary, Repeat Prescription Manager. A letter of the 27 September 2000 also confers the title of Head of Operational Management on the Assistant Practice Manager. By itself this fact is unremarkable and of limited value however when one adds it to other evidence including Dr. Ghosh's evidence to the effect that the girls liked it if you gave them titles points to, at least, an unprofessional approach to staff matters.

23 We are satisfied the relationship between Dr. Ghosh and Nurse Hunter had broken down to the extent where there was barely any communication between them. Any discussions between the two had to go through third parties. Dr. Ghosh would not acknowledge Nurse Hunter or take part in any meaningful conversation with her. Not once during her employment with the partnership (2001 to 2003) or whilst working for Dr. Ghosh alone (2003 to October 2004) was Nurse Hunter able to discuss particular patient needs with him. He was curt and dismissive of her at all times. We accept what she says about that and further rely on the relatively impartial view of Nurse Kelly (and supported by Joan Armitage) who worked as chaperone in the practice between Christmas 2003 and April 2004. Her description was that the relationship was 'dysfunctional'. The lack of communication made Nurse Hunter's task very difficult. Although Nurse Kelly could not recite any example of when the lack of relationship impacted upon patient care we of course have found that a significant factor in the lack of appropriate treatment for Patient B was the failure of Dr. Ghosh to properly deal with concerns Nurse Hunter attempted to raise. At no stage was there any attempt by Dr. Ghosh to establish a proper working and professional relationship with an essential member of the clinical team.

24 Again both Nurse Kelly and Joan Armitage describe how staff would become frequently upset. Some cried, others were unhappy and not sure where they stood. Nurse Kelly described the staff as 'walking on eggshells'. Their evidence is particularly balanced because both confirm they never had any problems with Dr. Ghosh . Nurse Hunter describes hearing shouting and staff crying although never in her presence. Of course staff can become upset for reasons unconnected with their unemployment but our unanimous impression is of an employer who set out to manipulate and at times belittle staff. J. Tynemouth gives but one example of Dr. Ghosh talking about a member of staff to another member of staff whilst in the presence of the first person but ignoring that person entirely.

25 We are urged on behalf of Dr. Ghosh to pay little regard to the findings of The Employment Tribunal on 29 December 2004 in respect of a claim by Miss S.J. Hudspith on the basis we have not heard direct evidence from the complainant in that case. If we are to have regard to the findings, so it is submitted, we must also take into account the fact that the only oral evidence we have heard is the exculpatory statement of Dr. Ghosh and his explanation why he did not appeal the decision. The findings of the tribunal are the public record of a competent jurisdiction, specialised in employment issues. Dr. Ghosh has not raised issues of fraud or collusion in the making of that decision, nor sought to introduce fresh evidence

which could not previously have been obtained by reasonable diligence to show conclusively the previous decision was wrong. We rely on the findings of The Employment Tribunals as a demonstration of Dr. Ghosh's improper conduct toward employees, although we bear in mind the most serious allegations in those proceedings relate to conduct at a social occasion outside the usual employer/employee environment.

26 The GMC's Good Medical Practice Guidelines (para.34) states

" you must always treat colleagues fairly. In accordance with the law, you must not discriminate against colleagues including those applying for posts, on the grounds of their sex, race or disability. And you must not allow your colleagues lifestyle, cultural beliefs, colour, gender, sexuality or age prejudice your professional relationship with them".

Dr. Ghosh breached the duty of fairness in the manner in which he dealt with staff of the practice.

27 The difficulty in determining which conduct amounts to inefficiency and which to unsuitability is well known. Department of Health advice to PCTs considers efficiency to relate to everyday work, inadequate capability, poor clinical performance, bad practice, repeated wasteful use of resources or activities which add significantly to the burden of others. In a further refinement it attempts (in annex E to the advice) to offer examples of clinical capability such as out of date clinical practice; inappropriate clinical practice that puts patients at risk; incompetent clinical practice; inability to communicate effectively; inappropriate delegation of clinical skills and ineffective team working

28

(i) In the manner Dr. Ghosh failed to record important details; failed to ensure a new patient check was undertaken and failed to prepare an adequately full referral in respect of Patient A, we find inability to communicate effectively, inadequate supervision of delegated clinical tasks, inadequate record keeping and ineffective team working skills.

(ii) In the manner Dr. Ghosh failed to deal appropriately with Patient B we find incompetence, an inability to communicate, inadequate supervision and ineffective team working skills

(iii) In the manner the PSA tests were undertaken and results managed, we find inability to communicate effectively, inappropriate delegation of clinical responsibility, inadequate supervision of delegated clinical tasks and ineffective team working.

Which together amount to an "efficiency" case.

29 "Suitability" as a ground for removal from a Performers List is said by the Department of Health advice to include the consequence of a decision taken by others e.g. a court or professional body or a lack of tangible evidence of a doctor's ability to undertake the performer role, for example satisfactory qualifications and experience or an absence of essential qualities. The distinction between "efficiency" and "unsuitability" is important – a practitioner may remain on the list subject to conditions in respect of the former but must be removed in case of the latter. The Panel has considered carefully whether its findings

adverse to Dr. Ghosh in respect of what may be generally described as staff matters falls within efficiency or unsuitability. It concludes (not without hesitation) the breach of the duty to be fair to colleagues by, amongst other things acts of discrimination, rudeness, abruptness and favouritism, demonstrates a lack of professionalism falling within inadequate supervision, lack of communication and ineffective team working i.e. efficiency rather than unsuitability.

30 After careful consideration (and again not without hesitation), the cumulative "efficiency" as we find it is not sufficient to propel Dr. Ghosh beyond the line into unsuitability. The consequence is that we are required to consider whether to order removal from the PCT's Performers List or consider whether contingent removal is a rational and proportionate response to the "efficiency" issues as we find them.

31 Dr Ghosh has been in practice in the Blyth area for many years. Previously he was part of a 6-partner firm which later reduced to four, then two (with Dr. Mcollum) but since 2003 he has practiced single-handed. There seems to have been little by way of a supportive partnership environment between Dr. Ghosh and Dr. Mcollum so Dr. Ghosh has probably been in effective charge of a practice since the late 1990's. This period has coincided with significant changes in the way primary care is run and provided – changes we find Dr. Ghosh has been unable to keep up with, for example the introduction of computerised record keeping. His management style is inappropriate and his attempts at implementing internal systems (i.e. well man clinics, PSA testing etc.) ad hoc and chaotic. Against that he clearly has the support of a large body of the community including the local M.P. and a range of satisfied patients many of whom have attested to Dr. Ghosh's tireless efforts on their behalf. Some members of staff have been happy to confirm they would continue to work with Dr. Ghosh, despite his problems with the courts, PCT and GMC. We are mindful that significant clinical shortcomings have been found only in the case of patient B, and that was partly related to communication issues. He remains professionally enthusiastic, attempting during his most recent suspension to arrange a training programme with the local Post-Graduate Dean and between May 2005 and March 2006 attending something like 19 lectures, seminars or teaching courses

32 We are satisfied Dr. Ghosh does not have (or the insight necessary to acquire them), the personality or skills to undertake management responsibilities within modern general medical practice, but his clinical abilities and experience can still be used to advantage. We wish to design conditions to ensure Dr Ghosh's skills have been maintained at an appropriate level since his suspension in January 2005; protect him from management responsibilities and ensure adequate, ongoing peer appraisal and support. Either party has the right to apply to the FHSAA for conditions to be varied under 15(6) of The National Health Service (Performers Lists) Regulations 2004.

33 On a finding of "an efficiency case" (10(4) of the Regulations) we order Dr. Ghosh be contingently removed from the Performers List of Northumberland Care Trust with conditions that:-

(i) he shall not engage in general medical practice as a principal provider or, either direct or through an agency, undertake 24 hour emergency cover, but shall be limited to practice as an assistant, employee or provider of locum services in a practice with not less than 3 partners or full time equivalents.

(ii) before resuming practice Dr.Ghosh (at his expense) shall satisfy the Regional Post Graduate Dean (or equivalent) his clinical skills are up to date and that he is suitable to return to practice

34 Finally, in accordance with Rule 42 (5) of the Rules we hereby notify 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 from receipt of this decision.

DATED this…………day of………………2007

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Chairman