IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY
SITTING AT FHSAA, HARROGATE

Case No: FHS/13911

Panel Members:
Chairman – Mr Christopher Limb
Professional Member – Dr Suraj Sharma
Lay Member – Mrs Lorna Jacobs

BETWEEN:

DR SYED I AHMED
GMC Reg No: 3595673

Appellant

and

BLACKPOOL PRIMARY CARE TRUST

Respondent

DECISION

INTRODUCTION

1. This is our Decision upon the appeal of Dr Ahmed against the Decision of the PCT to remove him from their Medical Performers List on the grounds of efficiency and unsuitability pursuant to Regulation 10(4)(a) and (c) of the National Health Service (Performers List) Regulations 2004 ("the Regulations"). We sat in Harrogate for five days between 28th April and 2nd May when we heard oral evidence, considered written evidence, and received submissions from both parties. Dr Ahmed presented his case in person. The PCT was represented by Mr Anderson of Counsel.

2. The allegations made against Dr Ahmed by the PCT fall under four broad headings:

   (a) It is alleged that blood pressure measurements and recordings in March 2006 were not genuine but were "concocted" and for the purposes of enabling Dr Ahmed to obtain a payment under the Quality Outcome Framework ("QOF"). It is said that in addition to the obvious seriousness of falsifying records there is potential for harm to patients from the absence of genuine monitoring of blood pressure;

   (b) It is alleged that in March 2006 Dr Ahmed also concocted patient records in respect of epilepsy reviews. It is said that such was similarly for the purpose of obtaining a QOF payment. It is said that there was a consequential risk of harm to patients in the absence of genuine reviews taking place;

   (c) It is alleged that there was sub-standard and potentially harmful clinical care of various patients and in particular inappropriate medication;

   (d) It is alleged that at the time when he was suspended from the PCT's list, Dr Ahmed signed a Med 5 Sickness Certificate, and moreover did so without having recently examined the patient in question.

3. In addition to the four areas referred to in the previous paragraph, the PCT investigated other areas of concern references to which are contained in some of the papers. The PCT has made plain throughout that such other matters are not relied upon. The PCT made suggestions to Dr Ahmed prior to the hearing to redact documents to remove such references but Dr Ahmed did not respond. Such other matters have not been considered by us and the evidence referred to at the hearing and considered by us relates solely to the four areas of concern which are referred to in this Decision.

4. After initial investigation which centred upon the issue of blood pressure readings, the PCT's Performers Panel chaired by Mr Shaw conducted two interim hearings on 28th November 2006 and 9th January 2007. On 9th January 2007 Dr Ahmed was suspended from the Performers List pursuant to Regulation 13(1)(a), namely suspension while the PCT decided whether or not to exercise its powers to remove Dr Ahmed from the list on the basis of being satisfied that it is necessary to do so for the protection of members of the public or otherwise in the public interest. The PCT thereafter held a further hearing on 19th June 2007 at which Dr Ahmed was represented by Counsel and at the end of which the PCT decided to remove Dr Ahmed from the Performers List. The Decision letter was dated 21st June 2007. Dr Ahmed thereafter gave Notice of Appeal and by reply of 14th August 2007 the PCT indicated its intention to oppose such appeal.

5. The proceedings before the FHSAA have a lengthy and slightly complex history. References to Orders in this paragraph are no more than summaries but are briefly set out to explain the circumstances in which Dr Ahmed was not allowed to give oral evidence at the hearing before us.

   On 8th October 2007 an Order was made requiring both general disclosure and also specific disclosure of various identified documents. Service of witness statements was provided for. The PCT complied. Dr Ahmed did not comply and the PCT made an application for an Order that Dr Ahmed show cause as to why the appeal should not be dismissed by reason of his failure to comply with the previous Order. Contact between Dr Ahmed and the offices of the FHSAA indicated that Dr Ahmed had not received the Order of 8th October 2007 but he confirmed by phone that he then received the document on 25th October 2007. The hearing of the appeal was initially fixed for 21st-23rd November 2007 and on 12th November Dr Ahmed sought an adjournment. We adjourned the hearing having received some medical evidence from Dr Ahmed's treating consultant but gave further directions on 28th November 2007 which provided for both general and specific disclosure of documents and for Dr Ahmed to provide copies of statements of all witnesses upon whom he intended to rely. The Order specifically provided that Dr Ahmed would not be permitted to rely upon documents not disclosed and not be permitted to rely upon witnesses in respect of whom a witness statement had not been disclosed. Specific reference was made to Rule 36 of the Family Health Service Appeal Authority (Procedure) Rules 2001 ("the Rules"), namely the power to dismiss in whole or in part in the event of failure to comply. By letter of 21st December 2007 the PCT applied for dismissal on the basis of non-compliance by Dr Ahmed with the Orders and in particular his failure to provide specific documents or to serve witness statements. There was difficulty in fixing a date which was mutually convenient to all concerned but on 18th April 2008 we heard oral argument from both parties. We refer to the Order made (initially given orally and in longhand on the day and subsequently in typescript on 21st April). We did not dismiss the appeal but ordered that no further documents would be considered other than those already disclosed and that Dr Ahmed could not call any witnesses (having served no statements) and could not give evidence himself unless he provided a witness statement by 23rd April 2008. Dr Ahmed did not provide a witness statement either within such timetable or at all. As set out in our Decision in April Dr Ahmed was, when asked, unable or unwilling to explain the nature of the case he wished to rely upon or to refer us to disclosed documents which set out his case.

LEGAL FRAMEWORK

6. The appeal is brought pursuant to Regulation 15. Pursuant to Regulation 15(3) the FHSAA on an appeal may make any Decision which the Primary Care Trust could have made. The hearing is in the nature of a re-hearing and, unless the quality of evidence has been affected, the FHSAA is not normally concerned with arguments as to shortcomings or errors in the hearing against which the appeal is brought. We have treated the appeal as a re-hearing and decided the matter on the merits of the evidence presented to us.

7. By Regulation 10(3) and (4) the PCT may remove a performer from the list if "(a) 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 ("an efficiency case")". Pursuant to Regulation 11(5) a PCT must take into account in an efficiency case those matters set out in Regulation 11(6). Those matters are:

   (a) the nature of the incident which is prejudicial to the efficiency of the services;
   (b) the length of time since the last incident and since conclusion of any investigation;
   (c) any action by any licensing, regulatory or other body, the police or the Courts;
   (d) the nature of the incident and whether there is a likely risk to patients;
   (e) whether the performer has ever failed to comply with a request to undertake an assessment by the NCAA;
   (f) whether the performer has previously failed to supply information, make a declaration or comply with an undertaking;
   (g) the circumstances of any refusal of admittance, conditional inclusion, or removal or contingent removal or suspension from any PCT List or its equivalent;
   (h) (not relevant).

   By Regulation 11(7) the PCT in taking a Decision under Regulation 10 must take account of the overall effect of any relevant incidents and offences relating to the performer of which it is aware.

8. In an efficiency case, Regulation 12 provides that instead of removal the PCT may decide to remove a practitioner contingently and if it so decides must impose such conditions with a view to removing any prejudice to the efficiency of the services in question.

9. Paragraph 7.4 of The Department of Health guidance document "Primary Medical Performers Lists - Delivering Quality in Primary Care" (August 2004) indicates that efficiency cases concern issues of competence and quality of performance : "They may relate to everyday work, inadequate capability, poor clinical performance, bad practice, repeated wasteful use of resources that local mechanisms have been unable to address, or actions or activities that have added significantly to the burdens of others in the NHS (including other doctors)".

10. By Regulation 10(3) and (4) the PCT may remove a performer from the list if "(c) he is unsuitable to be included in that Performers List ("an unsuitability case")". Unsuitability cases sometimes concern decisions by Courts or professional bodies. The Regulations contain specific references in such regard but suitability may also be relied upon when a performer is properly considered to be unsuitable because of his actions or his character. In paragraph 7.11 of the Department of Health guidance document we note that it is said : "The term is used with its everyday meaning and so provides PCTs with a broad area of discretion. Suitability and efficiency grounds may overlap and in many cases a PCT may find itself able to take action against a doctor under either ground. It is unlikely that a PCT would be accused of acting wrongly by using efficiency grounds to remove a doctor who had been convicted of serious violence, or by using unsuitability as a ground for removing a doctor who had defrauded the NHS.

11. The burden of proving the allegations against Dr Ahmed rests upon the PCT. The Panel recognises that the allegations in this case are serious allegations and that cogent and compelling evidence is required if they are to be found to be proved. When considering whether we are satisfied on the balance of probabilities that an allegation is established we bear in mind that the more serious the allegation, the less likely it is that it occurred and the stronger should be the evidence before we conclude that the allegation is established.

FACTS/EVIDENCE

12. We shall refer in summary form to the evidence and our conclusions upon such evidence in each of the four broad categories of allegations already set out. Prior to doing so, we indicate our general assessment and impressions of the witnesses we heard. Mr Gornall is employed by the PCT with the title of Deputy Director of Commissioning for Primary Care. He was one of the people involved in organisation of the investigations relevant to Dr Ahmed and present at some of the meetings with Dr Ahmed. We found him to be an honest witness. In general terms he appeared to have good memory of the matters in respect of which he gave evidence and on any matters in respect of which his recollection was in rather more general terms he was able to refer to contemporary documentation to provide detail. He remained calm and measured in cross-examination even when Dr Ahmed made serious allegations against either him or the PCT. We generally found him a reliable witness. Mr Harrop is a pharmacist by profession. He is the Clinical Audit Manager of the PCT. He gave evidence in relation to audit issues and in relation to other matters with which he was involved such as meetings or interviews with Dr Ahmed. We found him a clear and helpful witness. He was forceful in personality but not inappropriately so. Mr Hagan is the local Counter Fraud Manager employed by the Regional Internal Audit Service. He was involved in some of the general decision making and evidential investigation and also in meetings with Dr Ahmed. We found him to be straightforward and reliable. Mr Roberts is an independent Risk Management Consultant engaged by the PCT for the purpose of investigating concerns as to Dr Ahmed. His primary role was in relation to interviews of Dr Ahmed and subsequent written reports. There was no substantial challenge to his evidence. We found him to be straightforward and reliable.

13. Dr Calvert is a General Medical Practitioner by profession and continues to practice as such. From August 2006 he was appointed in a part-time executive role of Director of Clinical Engagement for the PCT. From the time of his appointment he was involved in some of the decision making and organisation of the investigation and also in meetings/interviews with Dr Ahmed. He was (together with Dr Phillips) a witness relied upon by the PCT in relation to matters of expert opinion as to standards of general medical practice. We found him in general terms to be an honest witness who was measured and balanced in his answers. In relation to his evidence as to standards of professional practice we were satisfied that he was not only clear and reasoned in his opinion but was applying the appropriate standard of comparison with the average/competent general practitioner rather than the optimal or very best practice for a general practitioner (i.e. he was not applying too high a standard).

14. Mr Shaw is the Chairman of the PCT. Prior to such post his general background is as an accountant and in commerce. He chaired interim hearings on 28th November 2006 and 9th January 2007 and also the final hearing of 19th June 2007 which made a decision to remove Dr Ahmed. We found him to be straightforward and honest in his evidence. His evidence was not the subject of any notable challenge.

15. Mr Bond is Head of Information Technology with the PCT. He gave evidence as to the computer software and in particular as to whether or how it was possible for entries to appear to have been made on a date other than the date on which they are

actually made. He was not the subject of any substantial challenge. We found him to be straightforward and reliable.

16. Dr Phillips is a General Medical Practitioner and continues in practice in Blackburn. He is an External Clinical Advisor to the PCT. His principal role is to provide an external and independent professional opinion. He was (together with Dr Calvert) a witness who gave evidence as to the standard of care provided by Dr Ahmed. We are satisfied that he adopted an appropriate test equivalent to that of the average competent general practitioner. We found him to be honest and a very impressive witness who gave his evidence in a measured manner and without exaggeration. He was self evidently of independent mind.

17. Dr Ahmed conducted himself politely throughout. It was not always clear to what extent he challenged allegations. It was not always clear what if any positive alternative case he was suggesting to witnesses. The Panel attempted to assist him but on occasions it appeared that Dr Ahmed deliberately failed/ refused to clarify the case he was putting forward : we refer later in this Decision to his use of a blood pressure monitor on Dr Phillips and whether on the one hand he was suggesting that he demonstrated a proper examination with the monitor at the level of the heart when on the other hand he accepted that the monitor was at a low level or whether he was not doing anything other than showing a type of monitor with which Dr Phillips was unfamiliar and which he was not using to take a reliable blood pressure reading from Dr Phillips. Such is an example of his confused approach.

18. We shall summarise the evidence and our finding in relation to each of the four categories of allegations.

Blood pressure measurement and recording

19. The essence of the allegation is that all or the majority of the blood pressure reviews entered on the computer on 21st March 2006 were false and that the patients had not in fact been seen by Dr Ahmed. Blood pressure reviews of hypertensive patients are relevant for obtaining additional payments under the QOF system : such is the item attracting the largest number of points (153 of a possible 1,050 points). It was a standard review of data submitted for the purposes of QOF that initially led to investigations relevant to this case.

20. The data submitted by Dr Ahmed is conveniently confirmed in the bundle at D1-5. It shows that of 209 patients over the year ending March 2006, 48 had their data entered on 21st March 2006. Of those 48 entries, 47 were at or below the target level of 150/90 (systolic/diastolic blood pressure readings) and the data shows that of the 96 readings (i.e. 48 cystolic and 48 diastolic readings) all but 7 were even numbers.

21. The PCT relies cumulatively upon various matters in support of the allegation that the blood pressure data entered on 21st March 2006 from 14:56 hours onwards was false (it is accepted that two entries made at earlier times are probably genuine and relate to patients whose appointments at the surgery are confirmed elsewhere – D39). Reference is made to what was said by Dr Ahmed in interviews and at the hearing in June 2007 and to Dr Ahmed's letters or e-mails in the course of the investigation.

    (a) The PCT contends that it is inherently unlikely that the ratio of odd to even numbers would be so unbalanced. Although not expressly addressing this individual aspect in submissions or in any of the documents before us, we proceed upon the basis that Dr Ahmed suggests that such is simply a matter of chance;

    (b) In the context of Dr Ahmed contending that he saw the patients and recorded the readings informally upon a series of post-it sticky notes over a period of about three or four days, the PCT contends that the order of entries in ascending patient number would not be consistent with taking the readings from a substantial pile of post-it sticky notes. The PCT suggests that if there was a genuine collection of information upon post-it sticky notes it would have been easier and faster to enter the data in the order of the notes than to undertake a re-ordering of the notes to match patient numbers. Dr Ahmed in his submissions suggested that the order was the easiest way to enter the details because the list of hypertensive patients would appear upon "Population Manager" on the software system, although that is not something that had been previously raised in letters, e-mails or previous hearing or interviews;

    (c) The PCT alleges that the suggested means by which Dr Ahmed contacted his patients over three or four days leading up to 21st March is not credible. The suggestion of Dr Ahmed was a mixture of contacts by telephone, letter and opportunistic visits to the surgery by the patients for some other reason. They point to the lack of any disclosure as to telephone records, the absence of telephone numbers within the patient records for 15 of the 48 patients (table at C33-34) and the absence of any copy letter. Dr Ahmed did not directly address this particular aspect in his submissions save for the general observation that the information was genuine and the patients were seen for their blood pressure readings to be taken;

    (d) As illustrated on the graph at B323 the percentage of patients at target level of blood pressure as recorded on 21st March 2006 is 98% in contrast to 73%

at the time of patients' previous readings and 46% at the time of subsequent readings (albeit there was a substantial minority of patients who did not have a subsequent reading). The PCT says that it is inherently unlikely that the patients improved and worsened to such extent;

(e) The PCT urges that the accounts given by Dr Ahmed have been different at different times and that such is a reason to disbelieve the accounts given. The evidence of Mr Gornall and Mr Harrop was that at a meeting with Dr Ahmed on 4th May 2006 they specifically raised the issue as to whether the patients were all seen on one day (see their note at C1) and were told that all the patients had been seen and had their blood pressure recorded on the same day. The same note at C6 refers to contact having been made by phone. Dr Ahmed challenged such position in his letter of 16th May when provided with the PCT's note of the meeting. Dr Ahmed indicated in his letter that he saw the patients over three or four days. He referred to either seeing the patients either by chance when they attended the surgery of their own volition or alternatively because he telephoned them to ask them to attend (Practice letter at C9). The PCT contends that Dr Ahmed added the detail of recording the blood pressures on sticky notes at the time of seeing the patients. In his e-mail of 3rd May 2006 (C17) Dr Ahmed suggested such e-mail was his final explanation. The PCT refers to the meeting of 24th August 2006 with Dr Ahmed and attended by Dr Phillips, Mr Hagan and Mr Gornall and to inconsistent answers from Dr Ahmed as to the number of patients he had telephoned to attend, a variation between 15/20 and 30. The PCT contends that even if 30 had been telephoned such would involve the proposition that no less than 18 patients attended by chance and that such 18 patients must by chance have included the 15 patients who had no telephone. The PCT refers to Dr Ahmed referring for the first time to having written to patients in his oral evidence at the Panel meeting of 9th January 2007 with the suggestion of such letter being typed only arising in the submissions of Dr Ahmed's Counsel at the Panel meeting on 19th June 2007. In his submissions, Dr Ahmed did not directly deal with the alleged inconsistencies. He indicated in general terms that the patients had been seen and had been seen over three to four days;

(f) The PCT makes specific reference to two patients. Patient 724 is recorded as having attended for blood pressure measurement but on 20th March 2006 (F140) required a home visit for the purpose of dressing of wound post surgery. It is suggested that it is extremely unlikely that such a patient would have attended the surgery for routine blood pressure measurement. The PCT refers to the appointment of patient 3526 at 10am on 21st March (D40) which was in relation to scabies (consultation note at F392). They suggest that it is most unlikely that such a patient would have attended on a further occasion either on 21st March or in the three or four days preceding 21st March either by chance or upon specific request but rather have had both matters dealt with at the same time. Dr Ahmed did not address such matters specifically in his submissions.

22. One of the arguments raised in the Appeal Notice is the absence of direct evidence from the patients and the PCT's failure to interview the patients. By his memo of 13th September 2006, Mr Hagan asked Dr Ahmed for a list of names, addresses and telephone numbers of the patients for whom blood pressures were recorded on 21st March 2006. Dr Ahmed wrote to the patients (C21) indicating that the PCT wished to investigate whether their blood pressure had been taken before 21st March and continued "I feel very insulted and angry about it. I have provided them all the information but it seems they are acting with a hidden agenda. They are in violation of your rights. I am custodian for the confidentiality of your records, name, address and telephone number. I cannot and will not pass them your information. They have no rights to ask me to give it to them. If you feel that I can pass your name, address and phone number to them please sign the declaration form below. It will then

absolve me of any responsibility of confidentiality. Please remember that the confidentiality of any information which we hold for you will be in danger. Please forgive me for this letter. I can assure you I will fight for you to the end". The PCT contends that such letter was plainly intended to encourage refusal on the part of the patients. Of the 23 patients who replied, all but one refused consent. The PCT says that in such context they did not interview the patients. Dr Ahmed did not directly address this issue in his submissions.

23. The final matter referred to by the PCT in relation to the blood pressure issue is the monitor Dr Ahmed says he used. It appears to be common ground that the monitor must be used at heart level to achieve greater accuracy. At the hearing of June 2007, Dr Phillips was cross-examined by Counsel for Dr Ahmed on the basis that there was simply a demonstration of the monitor rather than an actual taking of blood pressure. This was in distinction to the interview of 12th March 2007 (B72) when Dr Ahmed said not that the arm was not raised because it was only a demonstration but that Dr Phillips was lying when he said that the arm was not raised so that the monitor was at heart level. In his submissions, Dr Ahmed appeared to revert to the position that the monitor was put on Dr Phillips solely to demonstrate how it worked rather than to take an actual reliable blood pressure reading.

Epilepsy reviews

24. The review of epilepsy patients was another category of treatment which potentially entitled Dr Ahmed to payment under the QOF procedures.

25. The PCT contends that the epilepsy review entries are false and were concocted. It refers to the 15 patients whose reviews are recorded as taking place on 17th March 2006 (four patients within 14 minutes), 20th March 2006 (six patients within 25 minutes), and 29th March 2006 (five patients within 45 minutes). As illustrated in the graph forming part of Dr Roberts' report at B30, such patients records caused a previous level of twelve months seizure free epilepsy patients of under 10% to rise to over 40% and qualify for QOF payments. Dr Ahmed's case was that the patients attended by "happenstance" : such had been indicated in interviews but was confirmed in the submissions before us. The PCT contends that such chance attendances are in the true sense of the word incredible and not to be accepted.

26. The PCT refers to Dr Ahmed's challenge to the accuracy of the timings and the suggestion that the computer recorded the wrong time or date. The PCT relies upon the evidence of Mr Bond as to the inability of Dr Ahmed or his staff to change the time and there being no evidence of any one within the technical support services having done so and that in any event any error would have been apparent in other ways such as back-ups taking place at the wrong time but not being so. The PCT also refers to the analysis of Mr Harrop (B326 and B328/9) showing that the overall times of consultations and activity in the day appear correct and there is not, for example, any activity outside the hours that the surgery would normally be operating. The PCT further contends that there was a specific example of Dr Ahmed deliberately trying to "manufacture" evidence in support of his argument that the computer software was unreliable and showed reference to a child aged 5 "never smoked tobacco". The PCT in particular refers to the evidence of Mr Harrop and to the electronic audit trail demonstrating that the specific quoted entry was added by Dr Ahmed rather than being an indication of the computer software erroneously generating such entry.

27. The submissions of Dr Ahmed confirm that he contended that the epilepsy patients attended within such short space of time by chance and without any request. He appeared to suggest that parts of the record entries other than number of fits, which were self evidently incorrect, were automatically generated by the computer from content of earlier entries, that he was aware that the records had substantial inaccuracies, but that he allowed the entries to remain in the records without taking any further action.

Individual clinical concerns

28. Although the PCT's investigations and concerns initially concerned the categories of hypertensive and epilepsy review patients, the potential implications for safety and wellbeing of individual patients are equally if not more serious for the patients within this category.

29. Several of the patients referred to can be conveniently referred to together as they involve related issues. Others are individual in their nature.

30. There are five patients in respect of whom the PCT alleges that doses of steroids were too high, that the period over which prescription was given was too long, and that there was a failure to consider and monitor for potential side effects and in particular osteoporosis. The patients in question are (using patient numbers) 1490, 2681, 1029, 3099 and 2317. An initial reference to patient number 2137 was accepted to be an error and was a transcription error in respect of patient 2317. In all cases steroids had been prescribed for several years (up to ten years). In all cases it was alleged that there was an absence of review and absence of documented consideration of whether the steroids were necessary or whether an alternative treatment was appropriate. It is alleged that there was a lack of use of screening for side effects such as osteoporosis despite local availability of Dexa scanning for some years. In respect of patient 1490 it was further alleged that steroids were entirely inappropriate (even for a shorter period) because the condition being treated was irritable bowel syndrome rather than inflammatory bowel disease and it was only the latter which potentially might be treated with steroids. Neither in the interviews of which we have copies nor in submissions did Dr Ahmed deal with all individual patients at length but in broad terms submitted that the scanning service for osteoporosis was not readily available and that patients with osteoporosis would attend of their own volition if they had symptoms.

31. Dr Calvert gave evidence both in writing and orally. He indicated that not only was long term repeated steroid treatment generally contraindicated but that there were specific problems in the context of the individual patients. Patient 2317 developed classic cushinoid syndrome from over-treatment with steroids and required specific referral and treatment in such context in 2007 as well as treatment in relation to risk of osteoporosis. In relation to patient 1490 there were indications in 2007 of possible degeneration of the hip and/or avascular necrosis. There was also depression. All such matters were known side effects of prolonged steroid treatment. Patient 2681 developed diabetes after three years of repeated steroids : this is a known potential complication. There were also indications of hypertension and thrombo-embolism which are further recognised complications of long term steroid treatment. Patient 1029 was an asthma patient who had not received any documented regular review nor been referred for scanning in relation to osteoporosis. Patient 3099 had been prescribed large doses of steroids over four years without any recorded monitoring of potential bone thinning complications. Although Dr Phillips primarily gave evidence as to the first two categories of patients he also gave supportive evidence (albeit in less detail) in relation to the individual patients.

32. In relation to patient 1490 Dr Ahmed suggested in submissions in very broad terms that steroids could be given for irritable bowel syndrome but referred to no source of information or advice to support such proposition.

33. In relation to patient 1490 both Dr Calvert and Dr Phillips also gave evidence that prescribing of three different anti-depressants at the same time is extremely poor practice. Although the matter was not explored in depth we understood their evidence to be that it was likely to be both ineffective and potentially harmful.

34. Dr Ahmed agreed that his treatment of patient 2187 was inappropriate. She had been given an oestrogen-only hormone treatment despite having a uterus : a practice

which carries an increased risk of uterine cancer. In 2007 she presented with post-menopausal bleeding and was referred to a gynaecologist.

35. Patient 880 was a middle aged man with a complex history of diabetes, hypertension, left ventricular heart failure and gout. He was given Indomethacin which Dr Calvert indicated was used only with great caution in diabetics because of the increase of the risk of bleeding. Such was a far greater risk if (as in this case) Warfarin was also being given. The drug Reductil was said to be inappropriate for patients with coronary artery disease. Moreover the patient was on two similar treatments for hypertension with ACE inhibitors at the same time and such is generally inappropriate and only to be undertaken in rare cases and in specialist centres according to Dr Calvert. Dr Calvert's overall view was that the treatment of patient 880 was "completely inadequate and unacceptable". In his submissions Dr Ahmed made extremely limited, almost perfunctory, reference to this patient.

36. Patients 3598, 381 and 3716 were all given Vardenafil, a potential treatment for patients with erectile dysfunction. Dr Ahmed appeared to accept Dr Calvert's evidence that there were clear NHS prescription guidelines and that the only potentially relevant justification was if there was a patient with "severe distress as a result of impotence", in which case prescription was to be at "specialist centres". The guidelines were available in the papers before us. Although Dr Ahmed addressed us upon the use of Vardenafil it appeared that he relied upon rather vague references to distress or upset. In relation to patient 3716 Dr Calvert gave further evidence that his investigations led him to conclude that Dr Ahmed's letter at the time of referral to a psychosexual clinic indicating that blood tests had been carried out was not apparently correct and that there was no record of any tests having been performed (either in Dr Ahmed's records or at the laboratory). In relation to patient 3716 it was also alleged that Dr Ahmed failed to refer back to the consultant after an ECG showed an abnormality.

37. There were initially allegations made by the PCT in relation to patient 5630. These were not pursued : it was accepted that more than one doctor had been involved and that it was inappropriate to hold Dr Ahmed responsible for any errors.

38. Med 5 Sickness Certificate

Dr Ahmed did not dispute as a fact that he signed a certificate on 23rd May 2007 after his suspension. A copy of the certificate was before us. The part of the certificate which would normally be completed with reference to either an examination or alternatively identification of other source of information is not completed. It is however completed in the later part which contains the words "(I..) advised you that you should refrain from work" between specified dates from March to 18th May 2007. The certificate was dated and signed by Dr Ahmed on 23rd May. There was no suggestion in submissions that Dr Ahmed had in fact been involved recently with the examination or treatment of the patient but rather that he signed the certificate because he was present at the surgery when the locum doctor refused to give the certificate and the patient was threatening violence.

FINDINGS

39. In addition to the observations related to specific issues, Dr Ahmed made certain submissions of a more general nature. In one form or another he emphasised that he was an honest doctor who was much respected and liked by his patients. He indicated that there was a history of ill feeling towards him by some personnel involved with the PCT, though not making such an allegation against any individuals who gave evidence. He also made reference in various forms to the immense stress of the allegations caused by the allegations and proceedings. We take account of the foregoing but find them of little direct assistance in deciding the case. We have no reason to doubt that Dr Ahmed is well liked by his patients. We have no detailed

evidence as to poor personal relationships or associated animosity towards Dr Ahmed, but more importantly Dr Ahmed at no stage indicated by what means he suggested such matters were relevant to the conduct of the individuals who gave evidence before us and who were the principal decision-makers and investigators for the PCT. At best such submissions appear to indicate that we should take care in considering the reliability of the evidence : we have done so but would have done so in any event. We have no reason to doubt that the allegations and proceedings have been a source of great stress. More generally we note that there were various aspects of the case which Dr Ahmed did not address or address in detail in the course of either cross-examination or submissions (despite numerous attempts by the chairman to suggest greater order in the way he addressed issues) : we have throughout borne in mind that he is unrepresented and we have therefore approached the case upon the basis that except in relation to any matter which has the very clearest indication of agreement from Dr Ahmed all matters should be assumed to be in dispute.

40. In our review of the evidence relevant to the hypertensive patients and blood pressure recordings we accept that it is appropriate to look not only at the individual aspects but also to look at them cumulatively when deciding whether the allegation of concoction is established. Such is plainly a very serious allegation. As a matter of commonsense we find that the recording of only 7 readings which are odd numbers as opposed to 89 readings in even numbers is improbable in the absence of any convincing explanation. There is no suggestion that approximate or rounded readings were used as a matter of policy or practice. We considered that the explanation for the number of patients attending in such short period of time was not convincing. To the contrary we are satisfied that Dr Ahmed revised and supplemented his explanation as to how such large percentage of patients attend in such a short period of time. We accept the PCT's witnesses in their relation of what was said in interviews and also by reference to Dr Ahmed's letters or e-mails. Such indicates a pattern of inconsistency which was reflected in the style of Dr Ahmed's presentation to us. We remind ourselves that the patients in question were hypertensive patients. In such a context the percentage which were on target is surprisingly high. Such conclusion is fortified by reference to the lower levels of achieving target levels both before and after March 2007. We do not find it is credible that something in the order of a third of the patients, 15 patients, who had no recorded telephone number should "happen" to attend the surgery within such a short period of time. Such conclusion is reached regardless of whether Dr Ahmed's case was that the patients attended on a single day or attended over three or four days.

41. We consider that the PCT's criticism of Dr Ahmed's letter to patients in relation to provision of their records to the PCT and Dr Ahmed's criticism of the PCT for not interviewing patients are in substance neutral matters which do not greatly assist us one way or the other. We were not impressed by the letter which Dr Ahmed wrote to his patients and we understand why the PCT did not further approach the patients in the aftermath of such letter. Our approach to such issue is that we must proceed on the basis of the evidence available to us : neither party has relied on oral or written evidence from any of the patients in respect of whom blood pressure readings were recorded. We were not impressed by the inconsistent position of Dr Ahmed in relation to the use of the wrist blood monitor on Dr Phillips. Had Dr Ahmed given evidence himself such is a matter which may have influenced us in relation to his credibility. In the actual context of Dr Ahmed not giving oral evidence and whilst we accept the evidence of the PCT's witnesses as to the position of the monitor below heart level, this is not an aspect of the evidence which we find of particular assistance. Both matters referred to in this paragraph are in our opinion essentially neutral in terms of assisting us in reaching our conclusions.

42. The combination of the matters referred to in paragraph 40 cumulatively leads us to be satisfied that the patients did not attend either on 21st March 2006 or within three or four days prior to 21st March 2006 to have their blood pressure readings recorded. We find the combination of the various aspects of the evidence provides cogent and

compelling evidence. We find that the recordings were not genuine. In our opinion the only purpose of such recordings can have been to obtain additional payments under the QOF procedures.

43. By reference to the evidence in the case but also as a result of what we believe is commonsense (and assisted by our professional member Dr Sharma) we are of the view that it is self evident that not only is false information within a patient's medical records unethical but also of potential harm to the patients. The very purpose of following hypertension guidelines is that regular monitoring allows early intervention when a potentially harmful reading or readings is noted. A falsely normal blood pressure record might lead to increased risk of stroke or other serious cardiovascular complication. Such is doubtless the very purpose and reasoning for the hypertension monitoring having a prominent position within the QOF system of additional payments.

44. In relation to the patients recorded as having had an epilepsy review we find that it is (in the absence of any very specific explanation) incredible in the true sense of that word that 15 out of 18 potentially relevant patients should attend at the surgery by chance within a three day period. It was accepted that the patient records were left with other entries appearing to be made on the day of the alleged record of recent fits and that such other entries were not the subject of any further history or examination or finding : in other words such other entries remained as though made on the day of the alleged entry as to recent fits but were false even on the case of Dr Ahmed. We were satisfied from the evidence we heard and in particular the audit trail that the reference to a child and smoking was an entry made by Dr Ahmed on a separate occasion to the other parts of that record. Taking all the foregoing matters together we are satisfied that the submitted record of epilepsy reviews (even restricted to that part of the records referring to number of fits) was false and did not arise from actual attendance of the patients.

45. As in relation to the hypertensive patients we are satisfied that not only is the making of a false record a serious matter in principle but that the absence of any review and the potential reliance upon false information in the future are matters which could potentially harm the health and wellbeing of the patients in question.

46. We now turn to consider the allegations in relation to medication and other treatment of individual patients.

47. We refer to the evidence in relation to the five patients in respect of whom allegations were made concerning long term prescription of steroids. Dr Ahmed referred us to no entries in any of the records to justify such long term prescription of steroids which are known to have potential damaging consequences. There can in principle be justification for such long term prescriptions but none was highlighted or identified in the present case. Moreover there are no documented reviews. The potential dangers are not restricted to risk of osteoporosis but Dr Ahmed's argument that patients could be relied upon to attend if they had "bone pain" did upon the professional evidence called by the PCT ignore not only the availability of bone scanning but that the condition can be already serious and difficult to treat before symptoms are apparent. In relation to the patient 1490 the implication in cross-examination and submissions by Dr Ahmed was that he failed entirely to recognise the distinction between irritable bowel syndrome and inflammatory bowel disease : in such a context even the initial use of steroids was inappropriate in this case. There was the additional feature of inappropriate use of three different anti-depressants at the same time in relation to the patient 1490 contrary to the evidence (which we accept) that such is not only likely to render treatment ineffective but also potentially cause additional problems.

48. Dr Ahmed accepted the inappropriate nature of treatment for patient 2187 but neither in the documents nor his submissions was any explanation given as to why such

treatment was considered appropriate at the time. There is serious potential risk of cancer with unopposed oestrogen.

49. In relation to patient 880 Dr Ahmed appeared to fail to appreciate either in earlier interviews or in submissions before us that the combination of factors in the history of the patient had to be considered. He also seemed to woefully ignore in his submissions the clear guidance that ACE inhibitors should not have been used except in rare cases and under specialist guidance. We find that there was no evidence to support any potential suggestion that there had been consultant involvement which advised the treatment as appropriate.

50. In relation to the patients given Vardenafil, Dr Ahmed recognised the NHS Guidelines and the only basis upon which he put forward an argument for compliance with such guidelines was that there was "severe distress". The evidence he referred to within the records was at best weak in such regard if not non-existent. We are not persuaded by any implicit argument that any form of upset can be said to amount to severe distress. By the very nature of the problem of erectile dysfunction there must be some form of distress in most cases prior to attendance at a doctor. The argument of Dr Ahmed would make a nonsense of the guidelines. In relation to patient 3716 there was the additional feature of the care relating to angina and an ECG abnormality in July 2004. There was plain indication of need for a referral in the event of the ECG showing abnormality. The ECG did show an abnormality and there was no such referral. Dr Ahmed sought to explain the absence of referral by reference to his own illness but confused the years in such regard, his own illness starting the Summer of 2005 and not 2004. The attempt to explain a failure in such regard was of concern in itself and indicated an attitude of seeking to deny the allegations without in any proper and professional way considering the allegations before responding to them.

51. The care of individual patients is a matter of grave concern. Taken collectively it is not in our opinion possible to come to any conclusion other than that there were cases of unacceptable treatment which were not isolated. Moreover there are in relation to prescription of steroids and Vardenafil plain indications of an almost wilful but unreasoned disregard of guidelines for treatment. We are satisfied as to the PCT's case not only on a factual level but also satisfied that in the cases of the patients referred to above the treatment was of an unacceptable standard for which no mitigation or explanation was given nevermind justification given.

52. Although there was very limited evidence in relation to the circumstances in which the Med 5 Sickness Certificate was signed by Dr Ahmed we are proceeding in this Decision on the basis that such was signed in the context of the locum doctor having refused to give a certificate but the patient threatening disruption or violence as a result. Although Dr Ahmed did not raise the point we considered carefully whether his suspension prevented the giving of such certificate and came to the conclusion that such certification must be considered within the ambit of provision of primary medical services from which he was suspended. The more serious aspect in our opinion was that without having been involved in the examination or treatment of the patient on that day Dr Ahmed overrode the refusal of the locum doctor who had in fact had care of the patient. Such would in our opinion amount to not only sub-standard but inappropriate conduct even if he had not been suspended from practice. If not justification we accept that there might have been strong mitigation if there was a very real fear of violence from the patient but such could only be understandable if action was taken shortly thereafter to remedy the situation and give appropriate notice those who might otherwise rely upon the certificate. No such action was suggested to have been taken by Dr Ahmed.

CONCLUSIONS

53. We have found that the blood pressure records and the epilepsy review records were concocted and false. Such indicate entirely inappropriate conduct on the part of a General Medical Practitioner. Applying the word "unsuitable" in its ordinary and everyday meaning such conduct does in our opinion make Dr Ahmed unsuitable to be included in a Performers List. We also take account of the fact that the number of patients involved was significant. We find no basis – and Dr Ahmed did not suggest any – for excusing such behaviour or even explaining such behaviour. In such a context we also note that the conduct of Dr Ahmed in relation to the MED 5 Sickness Certificate indicated a willingness to certify matters of which he did not have professional knowledge.

54. In considering the issue of efficiency we remind ourselves that we must take account of those matters specifically referred to in the Regulations and more generally that it is appropriate to look at the nature of the incidents, the potential risk to patients, the number of incidents in question, and any mitigating circumstances. All the findings which we have made indicate a standard of treatment which ignored the standard of acceptable competent practice and gave rise to a very real risk to the patients' health and welfare. We are also cognisant of the unwarranted burden such actions placed upon others in the provision of NHS medical services although our most important concern relates to the health and welfare of the patients. Dr Ahmed gives no suggested explanation for his actions almost all of which were flatly denied. The only possible mitigation he puts forward is his own illness. His own illness could not in our opinion in any sense explain his actions in relation to the blood pressure patients and the epilepsy patients and the MED 5 Certificate, and the illness does not coincide in time with the facts giving rise to individual clinical concerns.

55. In the foregoing circumstances we are satisfied that the case is proved in relation to both efficiency and unsuitability. In relation to unsuitability there is no provision for contingent removal. The number of matters which give rise to the findings and the absence of any basis for concluding that there would be a difference in approach in the future make consideration of contingent removal inappropriate in relation to the aspects giving rise to our finding of prejudice to efficiency of services. We dismiss the appeal and uphold the removal of Dr Ahmed from the PCT's Performers List.

56. Pursuant to Regulation 18A the FHSAA can after deciding to remove Dr Ahmed from a Performers List also impose a National Disqualification. We were asked to exercise such jurisdiction by the PCT and heard brief submissions from both parties. The PCT in effect argues that the matters giving rise to the removal were widespread and in no sense "local". Dr Ahmed asked us to consider that his professional life was of extreme importance to him.

57. There is no statutory guidance as to the principles to be applied when considering national disqualification but it is in our opinion proper to consider national disqualification in those cases where the findings against the practitioner are serious and are not by their nature essentially local in a sense of being objectively unlikely to have arisen had the practitioner been in a different area. In the context of the number of matters involved in this case it may well have influenced us little even if there was an argument as to prospects of a material change in the conduct of Dr Ahmed in the future. In our view the facts giving rise to our findings of conduct prejudicial to efficiency and of unsuitability are very serious matters when taken together and are not local in nature. There is no explanation for such extensive and inappropriate conduct which might lead us to consider that conduct will be different in the future. The matters giving rise to our findings are widespread in nature and number. We are satisfied that an Order of National Disqualification is appropriate. We remind ourselves of the notable effect of such an Order and the practical consequence of preventing Dr Ahmed pursuing his career within the NHS. We weigh such considerations against the risk to patients if an Order for National Disqualification is not made. In our opinion there is a very real risk to patients if no Order for National Disqualification is made. We consider an Order for National Disqualification reasonable, necessary and proportionate.

SUMMARY

58. We dismiss the appeal of Dr Ahmed and uphold the Decision of the PCT to remove him from their Medical Performers List pursuant to Regulations 10(3) and (4)(a).

59. We order National Disqualification from inclusion on all Lists prepared by all Primary Care Trusts and Health Authorities including but not limited to those referred to in Section 49N(1) of the National Health Service Act 1977 as amended.

60. In accordance with Rule 42(5) we notify the parties that they can appeal this Decision under Section 11 of the Tribunals and Inquiries Act 1993 by lodging Notice of Appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days of the date of this Decision.

Dated the 14th day of July 2008

Chairman – Mr Christopher Limb
Professional Member – Dr Suraj Sharma
Lay Member – Mrs Lorna Jacobs