IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

Case Number: 13500

Listed at: **Birmingham**
On: **15th May, 11th, 12th and 30th July 2007**

Mr T Jones **Chairman**
Mr D L H Styles **Professional Member**
Mrs I Dale **Member**

BETWEEN

HEART OF BIRMINGHAM TEACHING PRIMARY CARE TRUST ("The PCT")

Applicant

and

DR OM PRAKASH ARORA
(Professional Registration Number: 2445320)

Respondent

Appearances:

For the Applicant: Miss Richler-Potts
For the Respondent: Ms F Neale for the Respondent

DECISION WITH REASONS

The Application

1. On the 9th June 2006 the Applicant PCT ("The PCT") removed the Respondents (Dr Arora) name from its NHS General Ophthalmic Services List ("GOS List") following a Performance Panel Review of the Applicant PCT. He was notified of

the removal and of his right of appeal therein. He did appeal but later withdrew the same. Subsequently, the PCT made an application to the FHSAA requesting the National Disqualification of the Respondent.

Background

2. Practice Management concerns were brought to the attention of the Applicant PCT's predecessor organisation in December 2001, following a routine Post Payment Verification Visit. Support and guidance was offered to the Respondent, who was practising as a high street Ophthalmic Medical Practitioner, over a four year period. It was acknowledged that some areas of performance did improve, but overall, only a limited improvement in practice management was achieved.

3. Accordingly, the Applicant PCT resolved in accordance with its duties, that a more proactive approach was required to address the same and commissioned two reviews of the Respondent. This resulted in the contingent removal of the Respondent from the GOS List in October 2005, subject to conditions: personal development, evidence of learning outcomes, preparation of practice policies, record audit keeping, appraisal and personal development of staff and observed clinical practice. The Respondent at that time was said to have acknowledged the need for help and did not seek to challenge the contingent removal or conditions.

4. The Applicant PCT undertook an audit in January 2006 and concluded "whilst there have been some improvement in previously poor areas there are areas where a previously achieved standard has fallen".

5. The PCT then moved on to ascertain the Respondent's clinical skills, as set out and notified to the Respondent in correspondence dated 30th October 2005. Arrangements were made for an Optometric Advisor for NHS Scotland, Dr Patel, to provide a report on the Respondent as to his standard of care provided to two consenting patients. This was arranged for 11th April 2006.

6. The report brought the issue of the clinical competence of the Respondent to the forefront of the Applicant PCT's collective mind. This was because; Dr Patel, amongst other things said in his report, concluded ".. he is in my opinion unsafe. He has a sufficient understanding and the basis of major conditions that can lead to permanent blindness if left untreated. However, his understanding of AMD (age related macular degeneration) is very poor. Considering AMD is a leading cause of registerable blindness and partial sight in the UK, I would expect an ophthalmic medical practitioner to be far more knowledgeable of its management. Dr Arora requires more training in the areas of modern primary care management of AMD, diabetic eye disease and glaucoma and a further assessment before it can be said he is of a sufficient standard required by those engaged in any primary eye care pathways directed and managed by the NHS." Terms of service are contained within the NHS Act 2006 and the NHS (General Ophthalmic Services) Regulations 1996 as amended. It is submitted that paragraph 10 of those same regulations require Dr Arora to have relevant knowledge and experience to identify injury, disease or abnormality and to take appropriate action to engage appropriate treatment or referral with the patient's consent. This includes where a patient is a diabetic, or glaucoma sufferer, to notify the patients GP of the results of any examination.

7. In light of the above the Applicant PCT, concluding there were potential implications as to patient safety felt there was no option other than to suspend the Respondent from its GOS List following a meeting held on 3rd May 2006. The Respondent had notice of the meeting but did not attend. The Applicant PCT later convened a meeting on 9th June 2006, at which evidence was received, and whilst it was noted that there were some areas of improvement in practice management. The review panel felt there was no prospect of rapid improvement in the standard and efficiency of services provided by the Respondent. The PCT, given a lack of marked improvement by the Respondent over the past 4 and a half years, and the potential risk to patients, resolved to remove the Respondents name from the GOS List and advised him of a right of appeal to this Tribunal. The Respondent did appeal, but later withdrew the same. Within three months of the same the Applicant PCT applied for national disqualification. There was an initial submission made that the Applicant PCT had not applied in time for the same; this issue was put to the parties by the Panel

at the hearing on 15th May 2007; it was made clear to us by Respondent's Counsel that it was not to be pursued. We found no merit in the application in any event, and proceeded to list the matter for full hearing with directions, allowing an application made on behalf of the Respondent for an adjournment to allow him to be assessed by an expert and to further prepare his case.

8. At the hearing we heard evidence from Dr Patel, and Mr Al-Ibrahim as expert witnesses. We also took evidence from the Respondent. A note of the same and of the closing speeches were taken by Panel members; we compared our notes and found no differences as to the same when using them in our decision making process. Indeed, we had asked the parties to remain for a short while after the conclusion of the proceedings in case we found a conflict in our notes.

9. It was submitted on behalf of the Respondent that the core issue before us was that of clinical competence. Practice Management, though a concern, were not matters that would have lead the Applicant PCT to remove the Appellant from the GOS List and seek national disqualification. It is said that the Respondent has made improvements, and notwithstanding suspension and removal, has made continued efforts to improve and his attendance re continued professional development should be noted.

10. Whilst the Applicant PCT relies on the assessment of the Respondent by Dr Patel - it was submitted that the assessment was for one half day only. The Respondent has practised for many years without prior complaint. It was submitted that the assessment when undertaken was such that the Respondent had had little notice of it, he was unfamiliar with the "viva" process of it, it was said Dr Patel was hurried if not impatient and he had set the bar too high.

11. The Respondent was also subject to scrutiny by Mr Al Ibrahim on 4th May 2007. It is submitted, that whilst his assessment of the Respondent could not include evaluation of refraction using a real patient, he concluded the Respondent was safe. It was submitted that it would be inappropriate to simply prefer one expert over another to determine the outcome of the application. We were asked to note the Respondents constructive approach, his continued efforts to maintain and improve his skills; that he should be seen as a resource and not a problem. His Counsel whilst saying that he acknowledged he had "become out of date, rusty, lost the habit of self improvement, became marooned in sole practice". Yet, he wishes to serve his patients still and improve, when many professionals of his age might not choose to do so. He has embraced the concept of continuing professional development. He has approached the local Deanery and others to help him and undertaken a more recent assessment too.

12. Counsel did address us in terms that the panel might think the Respondent was "below average". Counsel submitted it would be disproportionate, to nationally disqualify him, at the first sign of problem and without prior complaint. His high street practice was his main source of income; and, there is no basis for believing he will be unable to recommence practice, after a suitable period of updating his practical skills.

Our Decision

13. The power to make a national disqualification is contained in Section 159 of the National Health Service Act 2006. The exercise of our discretion is not specifically constrained or guided by statutory provision. It is available whether the ground for removal is a mandatory or a discretionary one; and if discretionary, whether on the grounds of suitability, fraud or efficiency. Ms Neale has rightly cited a number of panel decisions for our attention and whilst they do not bind us they are nonetheless helpful. In August 2004 the Department of Health provided guidance on national disqualifications and delivering quality primary care: PCT Management of Primary Care Practitioners Lists.

14. The guidance contains two relevant propositions: "where the facts of the case are serious it would wrong to allow the doctor to offer his services to every (PCT) in turn in the hope that he will find one willing to accept him". Further, "unless the grounds for their decision were essentially local it would be normal to give serious consideration … to an application for national disqualification". Therein, we refer to paragraphs 8.1.2 and 8.1.5 of the guidance notes referred to above.

15. In relation to this application, and set against any standard of proof, there are a number of matters that might be usefully addressed. They include findings concerning:

Clinical efficiency: We find that the Respondent's clinical efficiency to be markedly deficient. His Counsel, in her closing address, said we might well think he was below average. Dr Patel's assessment, and indeed the Appellants evidence and knowledge of clinical practice, after many months of claimed efforts to improve himself, only occasions us greater concern for the efficiency of the service and patient care. By way of example, the use of the Jackson Cross Cylinder technique. Dr Arora used this technique during the assessment by Dr Patel, who comments 'I have never observed a trainee optometrist or ophthalmic surgeon use the Jackson Cross cylinder in such an inappropriate way'. During the course of his evidence Dr Arora was asked to describe its use to us. What he described was fundamentally incorrect and, if the conditions are not set correctly before beginning the procedure then the results are of no value. Specifically, before this technique can be used effectively the patient, when asked whether the letters or circles are clearer on red or green, should reply 'green'. If this is not so then the whole procedure gives erroneous results. On two occasions during his evidence Dr Arora told us that greater clarity on the 'red' on the Duochrome test indicated an overcorrected myope and that 'green' indicated an undercorrected myope. This is quite the reverse of the true position. Lacking this basic knowledge invalidates the Cross cylinder technique. Whilst Dr Arora is quite correct in saying that a practitioner does not need to use this method, and could use others, if a technique is to be used it must be used correctly. We did not find the evidence of Dr Patel to be anything other than clear, concise and reliable. Notwithstanding cross examination, we found if anything this brought out issues where concerns were noted, but the benefit of the doubt had been given by Dr Patel. We found no substance in any assertion that he was hurried or impatient in his task. Mr Al Ibrahim had to concede he did not carry out the type of assessment Dr Patel had been able to; his report in one part could not be understood by any one, and when asked to explain it he himself could not do so. At one point our professional member had to query that which he had said concerning AMD. In his report Mr Al-Ibrahim opines that "the …OMP, should not express their opinion…for the sake of avoiding any conflict between the referring officer and the Ophthalmologist who is going to advice a disparate individual suffering from a visually disabling condition". In his evidence to the panel he stated that 'it was not for primary care to decide which type of wet AMD was present and whether it was amenable to treatment – it was outside his remit'. Our professional member put to Mr Al-Ibrahim that the identification of AMD is important in primary care due to the possible speed of referral needed. If a wet form of AMD is amenable to treatment the referral should be very quick to give maximum options for treatment within the treatment 'window'. In such a situation the primary care practitioner should be able to explain to the patient, in simple terms, what is going on and why the referral is so rapid. Mr Al Ibrahim immediately retracted that which he had just said, saying that he agreed entirely with what had just been put to him by our professional member. We did not find his input helpful as we might have hoped; and we attach little or no weight to his report or assessment of the Respondent. Mr Al Ibrahim notes that Dr Arora had impressed him, to the extent he makes especial note of it, that Dr Arora's attendance an International Ophthalmology Conference. We find that reference and reliance upon such to be misplaced, bearing in mind the conference was for but one day. We have further concerns re Clinical efficiency; specifically, Dr Arora's knowledge and understanding of the referral pathways and management a) of those with glaucoma and their relatives, and b) of those with AMD. In his report Dr Patel gives us details of the failings and lack of understanding demonstrated by Dr Arora and Dr Arora's own evidence only supported those views. In spite of the fact that he was aware for some time that he was to be assessed in a clinical situation, and that he had further time between the assessment by Dr Patel and the hearing to revise further upon these areas, he tells us, in his evidence that he 'did not know these four topics'. It seems that Dr Arora lacks insight into what is expected from a High Street practitioner in terms of clinical performance, as well as in record keeping. This despite his agreement that 'an experienced OMP would be able to achieve the same standard as a young newly qualified Optometrist' and his being provided with a detailed PDP showing the core competencies required (undated letter, page 129 of bundle). These core competencies have been produced by the General Optical Council for the pre-registration student optometrist to demonstrate before attaining registration. Under this heading we include also the matter of patient safety. We have serious concerns on this aspect of Dr Arora's practice and, by

way of illustration, use the case of the second patient provided by the PCT for him to examine. This was a male, Afro-Caribbean, aged 64. Dr Patel notes, and the Patient complains, that Dr Arora did not ask the patient if he was diabetic, or whether the patient or any of his relatives had suffered from glaucoma. The incidence of diabetes in the Afro-Caribbean population is higher than in Caucasians (though not as high as Asians), likewise the incidence of glaucoma in Afro-Caribbean's. Since Dr Arora tells us that his patient base is 'ethnic minority, mostly Pakistani, Indian, Afro-Caribbean and a few Caucasians' questioning in this area should be priority. In his evidence he tells us that he does not remember asking about the patients' family history of eye problems – again this should be at the forefront of his mind with a patient such as this. Additionally, we hear that Dr Arora has not received any complaints about his work. In his evidence he tells us that his patients from these ethnicities, living in a relatively poor area with many of them in receipt of state benefits do not complain, they 'accept what the professionals say'. This may indicate that the likelihood of complaint is low due to cultural reasons rather than an indication of complete satisfaction.

Practice Management: As was properly put to us; this may not have been an issue in respect of which the Applicant PCT might have relied upon solely. Ms Neale points to some areas of improvement. However, some slippage has occurred in areas of prior improvement since 2001. This is, we find, an inordinate time in which to find that only mere improvements have been made - when this is set against any competent practitioners own self wish to achieve total competence; let alone the input, in time and resource, as evidenced before us, and we find, clearly expended by the Applicant PCT and its predecessors.

Insight: It is clear to us, after a lengthy hearing, that the Respondent has not fully appreciated the lack of clinical skills required of him. He had to acknowledge this at the hearing. He acknowledged at the hearing his approach to further education and training also lacked direction; we find that this remains the case notwithstanding these proceedings, his contingent removal, suspension and removal from the GOS List. The Respondent has been aware of concerns as to his practice since 2001; and, of his clinical competence being the subject of further examination since October 2005. Worryingly, the Respondent in cross examination, when asked if since he knew his clinical competence was to be examined by the PCT sometime after October 2005, did he then start to revise for the same; the Appellant said "No – concentrated on development of the practice, on premises, that done first". He also had to accept that his performance as to practice management, given the input from the Applicant PCT and its predecessors was lacking; yes, there had been improvements but also slippage in areas of prior improvement. The question of insight was a concern to the Applicant PCT, reference is we find properly made to the same. At page R27 of the Applicant PCT's bundle where an Optometric Advisor to the PCT reports in October 2006 "...overall I was concerned that he had no insight into any of the issues raised by the PCT".

Remedial steps/Likelihood of timely future remedial steps: The Respondent and Counsel sought to impress us with the application to CPD. We note that the Appellant has attended lectures abroad; one such occasion was a lecture of only one day from a visit abroad of some weeks, taking Dr Arora away from weekly seminars he might attend with fellow clinicians in Birmingham. It may well have had an effect on his capacity during this time to pursue his re-training in the United Kingdom. An adjournment of these proceedings was required as a result of this trip. The visit to a conference in America, similarly, amassed but 120 minutes of CPD. The visit to Hull was not for an all day refraction and cataract seminar, as might be more appropriate to OMP practice; as can be seen from the certificate of attendance, it in fact related to refractive and cataract surgery, which he would not conduct on the high street. The error in this regard, in the Respondents statement, was said to be that of his instructing solicitor; we accept the Respondent has not sought to mislead us therein. The Respondent's visits to lectures and seminars when in Birmingham are not accredited, and the topics wide ranging; it was conceded they are not specific or dedicated entirely to OMP practice. The Appellant also attended an assessment in London in July 2007; that is to be seen for itself – it highlighted deficiencies in the Respondent's clinical skills particularly; Direct Ophthalmoscopy (to examine the eyes internally), Confrontation (a basic 'screening' of the visual field of a patient), Retinoscopy (an objective method of determining the refractive state of an eye – especially useful if there are communication difficulties between patient and practitioner), Subjective Refraction Distance and Near (quite simply, obtaining the

correct prescription for the patient), and Binocular Balancing (ensuring that the eyes work comfortably together with the prescription found). At the hearing we were concerned, despite the passage of time that his skills were still lacking. The Respondent himself had to concede this was so before us. The approach to the question of finding suitable training has been equally ineffective. The Respondent conceded that perhaps he might put more emphasis in finding training and mentoring more suitable to the work of an OMP than he has to date. In any event, it appears to us that those he has approached are unable, perhaps unwilling to assist him, or they are unsure as to where his priorities are. Prof Wall the Deputy Post Graduate Dean, as recently as 5th July 2007, comments "Unfortunately, I am not sure where Dr Arora's priorities lie at the moment"… he goes on to say; "I am not in a position to conclude anything about securing an assessment and for retraining in the West Midlands area as an OMP". The Respondent has been well aware for a long time now that his clinical skills were to be examined.

16. In determining the application made by the PCT herein, we find that the Grounds of Application are well made out. We find that the PCT was empowered and quite right to remove Dr Arora from their GOS List; and, in light of the Department of Health guidance and Panel decisions as noted above have quite properly, and we find quite rightly, made an application for national disqualification. The PCT's action we find was entirely proper and the current application proportionate. This because there is no doubt, against even the higher standard of proof, such that we find the assessment properly shows Dr Arora's performance therein was seriously deficient. His performance at the hearing, as highlighted above, was such that we have no confidence that Dr Arora is capable of true insight of his problems and shortcomings, and of his inability to remedy them within a reasonable time; nor do we find that we can rely on him to comply fully with any undertakings or efforts to improve his skills that he has yet to determine for himself in a timely manner. None of the explanations given by him as to these shortcomings gave us any reassurance; indeed, we found, the contrary was the case. Notwithstanding all that has been said for and on behalf of Dr Arora we find that PCT have been properly; and are rightly concerned, as to the risk to patients and the efficiency of the service such that a national disqualification is required. We make such an order. Dr Arora may apply for a review of this disqualification when two years have elapsed, and if matters yet proceed as he hopes and intends; he no doubt will consider this then.

Our Order

17. Our order is that pursuant to Section 159 of the National Health Service Act 2006, the Respondent Dr OM Prakash Arora (GMC registration number 2445320) be disqualified from inclusion in all GOS Lists prepared by all Primary Care Trusts, all lists deemed to succeed or replace such lists, by virtue of Regulations made there under. In so doing, proportionately, we have weighed the effects of this Order upon the Appellant, against the risk to patients and prejudice to efficiency if a national disqualification is not made.

18. We direct that a copy of this decision be sent to the bodies referred to in Regulation 47 of the Family Health Services Appeal Authority (Procedure) Rules 2001. Finally, either party to this appeal may exercise a right of appeal against this decision by virtue of section 11 of the Tribunal and Inquiries Act 1992, by lodging an appeal with the Royal Courts of Justice, The Strand, London, WC2A 2LL, within 28 days of receipt of this decision.

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Mr T Jones, Chairman
10th September 2007.