IN THE FIRST-TIER TRIBUNAL Case No. PHL/15312

PRIMARY HEALTH LISTS

BETWEEN

DR AYAKANNU KANDIAH

(GMC number: 2480529)

Appellant

AND

SWINDON PRIMARY CARE TRUST

Respondent

Panel:

Judge John Burrow

Dr R. Rathi- Professional Member

Ms J. Alderwick- Lay Member

1. Introduction

1.1 The hearing took place in the Jury Inn Hotel, Swindon from 21-23 March 2011. The Appellant was represented by Andrew Kennedy of counsel instructed by Radcliffes Le Brasseur. Also present for some or all of the days hearings were Shannett Thompson and Sam Flew of Radcliffes Le Brasseur. Dr Kandiah was present throughout and was called as a witness. Tanja Robinson who was practice manager at Sparcells Surgery was called as a witness. The Respondent, Swindon PCT, was represented by Roderick Clarkson of Beechcrofts Solicitors who called as witnesses Patient H and Mrs H, Paul Clark, Dr Elizabeth Mearns and John Reason.

1.2 This was an appeal by Dr Kandiah against the decision of the Swindon Primary Care Trust (PCT) to remove him from their medical performers list (MPL) pursuant to regulation 10(3) of the NHS (Performers List) 2004 (the 2004 Regulations) on the 14th September 2010. The removal was on the basis that the condition set out in regulation 10(4)(a) was met, namely that his continued inclusion on the MPL would be prejudicial to the efficiency of the services which are performed by primary care practitioners.

1.3 Dr Kandiah appealed on the 15th October 2010 pursuant to Regulation 15 of the 2004 Regulations, which provides that such appeals are by way of redetermination and that on appeal the first-tier tribunal may make any decision which the PCT could have made.

2. Legal Matters

2.1 Regulation 4(3)(b) states that the performer shall provide an undertaking to notify the PCT within 7 days of an material changes to the information provided in the application to the MPL.

2.2 Regulation 9(6) states that a performer who is included in the MPL shall act in accordance with the undertakings that the performer is required by these regulation to provide.

2.3 Regulation 11(5) (6) & (7) provide inter alia that the PCT and the Tribunal should have regard when considering removal of a performer in an efficiency case to the following criteria:

the nature of any incident which was prejudicial to the efficiency of the services which the performer performed,

the length of time since the last incident occurred and since any investigation into it was concluded,

any action taken by a regulatory body as the result of any such incident,

the nature of the incident and whether there is a likely risk to patients,

the overall effect of any relevant incidents relating to the performer of which it is aware.

Contingent Removal and Removal

2.4 Regulation 12 provides that in an efficiency case the PCT may remove the performer contingently. If it so decides, it must impose such conditions as it may decide on his inclusion in the MPL with a view to removing any prejudice to the efficiency of the services in question.

2.5 In *Dutt V Huddersfield Central PCT* [FHS/12359] August 2006 the FHSAA suggested the following issues might be appropriate to consider before contingent removal should be preferred to removal:

-whether the appellant acknowledged the extent of his inefficient practice

-whether the performer is able or willing to change

-whether a condition could be created which would have the effect of removing the prejudice to the efficiency of the services

2.6 In the Department of Health Guidance Document "Primary Medical Performers Lists: delivering quality in primary care- advice for Primary Care Trusts on list management" (August 2004), paragraphs 17.3, 17.4 & 17.16) provide that the discretionary power to remove should be exercised when necessary, with the protection of patients as the overriding factor in deciding what action is necessary. Removal may not be appropriate where issues can be resolved by remedial and/or supportive action. Conditions in efficiency cases might address poor performance or clinical shortcomings by imposing additional training or supervision in a particular area.

Efficiency

2.7 The Department of Health Guidance Document at paragraph 7.4 states that "in relation to what amounts to matters that would be prejudicial to the efficiency of primary medical services, the Guidance explains that:

"Broadly speaking, these are 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)."

2.8 In the case of *Kataria v Essex SHA* [2004] EWHC 641 (Admin) (para 69) Burnton J said,

"It is obvious that the efficiency of the NHS might be prejudiced by a want of probity in a practitioner, and in particular of any unreliability of his written or oral statements. Fellow practitioners and other NHS staff and patients must be able to rely on the integrity of doctors and the honesty of their statements. The FHSAA is entitled to take into account any want of probity found by it on the part of a practitioner in determining whether his inclusion in a list would be prejudicial to the efficiency of the service."

Professional Standards

2.9 Guidance on professional standards is contained in the General Medical Council (GMC) publication "Good Medical Practice". It states:

"2. Good clinical care must include

a. Adequately assessing the patient's condition taking account of the history (including the symptoms and psychological and social factors), the patient's views and where necessary examining the patient,

b. Providing or arranging advice, investigations or treatment where necessary,

c. referring a patient to another practitioner when this is in the patient's best interest

3. In providing care you must:

…

c. provide effective treatment based on the best available evidence.

48. You must be satisfied that, when you are off duty, suitable arrangements have been made for your patients' medical care…"

Burden and Standard of Proof

2.10 The burden of proof of an issue rests on the asserting party. The standard of proof is on the balance of probabilities.

Publicity

2.11 The Tribunal directs pursuant to Rule 14 of the Tribunal Procedure (First-Tier Tribunal) (HESC Chamber) Rules 2008 that there be no disclosure or publication of any matter likely to lead members of the public to identify any patient of the appellant who are referred to by only their initials.

3. The hearing bundle and evidence

3.1 The evidence consisted of the Hearing Bundle pages 1-375 along with the oral evidence of the witnesses called by the parties. Also considered were documents submitted during the course of the hearing which included pathology requests forms, printouts of the medical records of Patient H, and locum lists for Wiltshire issued in June and August 2010. The Tribunal also considered a document containing the opening submissions of the PCT and a document containing the closing submissions on behalf of the Appellant. Also considered were the various oral submissions on behalf of both parties.

4. The Evidence

4.1 After qualifying in medicine in Sri Lanka, Dr Kandiah came to the United Kingdom in 1977. From 1977 to 1987 he worked in General Medicine, in a paediatric post, and was trained in General Practice, becoming a GP Principal in Swindon in 1987 at the Sparcells Surgery. Following concerns about his practice in a number of areas, apparently due to overwork and lack of support, he was referred by the PCT to the NCAS for an assessment. The report from the NCAS was received in November 2006 and as a result of the report he was referred to the GMC and was asked by the PCT to refrain from seeing patients.

NCAS Assessment

4.2 The report indicated inter alia that Dr Kandiah has difficulties in communicating with patients and staff, particularly with women, and found it difficult to pick up on non-verbal communication which sometimes causes problems when carrying out patient assessments as

some information may be missed. He can be over familiar. The report also stated that on some occasions during patient assessments Dr Kandiah failed to ask appropriate questions or to take a full history, if any, from the patient. Dr Kandiah maintained there were no problems with his performance, rating himself as either 'good' or 'very good' throughout the assessment.

2007 GMC Performance Assessment

4.3 In March 2007 Dr Kandiah was asked by the GMC to undertake a performance assessment which was completed in September 2007. His practice was found to be unacceptable inter alia in the areas of assessment, records, treatment and relationships. The assessment team also found the areas of inter alia communication, respect, and education as being a cause for concern. The GMC assessors found there had been no significant areas of improvement from the time of the NCAS assessment one year previously, and they recommended that he should practice only part time and have a Deanery approved clinical supervisor. Undertakings were offered restricting his registration, but they were not accepted by Dr Kandiah.

GMC IOP Conditions of Practice

4.4 On the 4th January 2008 the GMC IOP imposed 19 conditions, including a condition to confine his medical practice to supervised posts in an NHS practice where his work would be directly supervised by a senior general practitioner, to a maximum of three days of clinical work a week, and to consult an educational supervisor with regard to improving his skills. He was also required by to inform the PCT of these conditions.

Contingent Removal

4.5 On the 9th June 2008 at a meeting of the PCT's Interim Order Panel, Dr Kandiah was contingently removed by the PCT from their performers list on the same conditions as were imposed by the GMC. The PCT's IOP imposed a further condition requiring him to complete his retraining programme by November 2008. The PCT agreed to fund locum cover fees up to the 14th November 2008. The contingent removal was reversed on 14th November 2008, once his training was completed.

Review of GMC Conditions

4.6 The conditions imposed by the GMC were reviewed on the 29th May 2008 and again on the 21st August 2008 when they were maintained unchanged. They were further reviewed on 9th February 2009 when the supervision condition was amended to one of mentorship and the restriction on the number of days he may practice a week was removed. These conditions were maintained until the 31st August 2010 when a condition of supervision was reimposed, the condition of mentorship was maintained, and a restriction that he must not work as a locum for less than three months was imposed. The condition of supervision was maintained by the FTPP decision of the 5th November 2010 and remains in place currently and until 3rd June 2012.

Training Programme

4.7 In September 2007 Dr Kandiah commenced a training programme under an educational supervisor Dr Damian Kenny and a trainer Dr Ballard. Dr Kandiah was to cease his practice at Sparcells and instead work alongside Dr Ballard for a period. A personal development plan was formulated in which the need to develop his record keeping skills was identified as a key educational need. A further area for development was Dr Kandiah's consultation skills. By the end of December 2007 Dr Ballard was reporting slow progress. Training was undertaken in these areas and in trying to improve his clinical performance. Dr Kandiah sat in on a number of Dr Ballard's surgeries, and practised producing patient records. By April 2008 his record keeping was said to have improved. Video recordings were made of a number of Dr Kandiah's consultations which were subsequently reviewed by Dr Ballard and Dr Kenny and it was said that he had significantly improved in this area.

4.8 At the end of April 2008 it was proposed that Dr Kandiah could return to working in his own practice on a staged part time basis whilst continuing to work alongside Dr Ballard for the remaining days of the week. He would remain in contact with Dr Kenny, and would discuss his consultations with Dr Julian Wilson, a GP trainer and mentor, at the end of each day. It was intended that Dr Kandiah undertake the AKT and CSA tests of the MRCGP.

4.9 On the 29th May 2008 the GMC IOP adopted these proposals and included them in the conditions of practice accordingly. In June 2008 Dr Ballard reported that his record keeping was much better and he was making more appropriate assessments of patients' conditions and formulating shared management plans with them. In July 2008 Dr Kenny noted good progress with clinical knowledge and consultation skills and that it was appropriate for him to undertake surgeries in his own practice for up to three days a week. Dr Ballard noted significant progress during Dr Kandiah's time at Dr Ballard's practice and it was envisaged he would no longer need to attend there. Dr Wilson would continue to visit the Sparcells surgery weekly and review the consultations each evening. Various suggestions were put forward as to further study for Dr Kandiah.

4.10 In July 2008 Dr Wilson commented on his willingness to learn and that his record keeping continues to steadily improve. He commented on Dr Kandiah's patchy knowledge base in respect of diabetes and that more work was necessary in involving the patient in management decisions. He said Dr Kandiah appeared to be making some progress, but there were some areas he might improve on. By September 2008 Dr Wilson said his consultation skills are developing steadily and that he had no major concerns and that weekly meetings were no longer necessary.

4.11 In May 2009 reports by Dr Kenny and Dr Wilson suggested there had been a significant improvement in Dr Kandiah's clinical work including improvements in his consultation technique, communication skills, clinical record keeping and clinical management. Thereafter Dr Kandiah remained in occasional contact with Dr Wilson as his mentor and with Dr Kenny who would review notes submitted by Dr Kandiah. Dr Kenny indicated he would be happy to continue to support Dr Kandiah in his professional

development. In an appendix to a report dated 19th April 2010 Dr Kenny noted Dr Kandiah's learning log which included on the 10th March 2010 a course concerning new advances in diabetes management and on the 6th February 2010 a course in diabetic management. Mr Clarke, the Assistant Director of Primary Care Commissioning at the PC, said that costs of providing locums during the retraining had been borne by the PCT and amounted to over £350,000 since 2006. Costs of training arranged by the Deanery were borne by Dr Kandiah.

August 2009 Test of Competence

4.12 On the 24th August 2009 Dr Kandiah was required by the GMC to undertake a further test of competence. In that assessment, his performance in the test of knowledge was found to be below the mean score for both a group of GPs and of practising doctors of all specialities and was found to be unacceptable. His performance in the simulated surgery in the areas of urethral syndrome and diabetic control was found to give rise to cause for concern, albeit his overall score in all 12 areas was 73.17 and overall he was considered to have performed in an acceptable manner in simulated surgery. He had improved his overall score by a significant amount in comparison with the test of competence in 2007.

4.13 His performance in the Objective, Structured, Clinical Examinations (OSCE) in the area of practical skills examination was found to be unacceptable. The areas of examining the mental state and dealing with colleagues were found to give rise to cause for concern. In other areas of the OSCE his performance was acceptable. The assessors concluded that there was evidence from both the simulated surgery and the test of knowledge that there were deficiencies in his knowledge base. They concluded that while overall performance was deficient, he was not considered to be a danger to patients. It was considered that he was fit to practice on a limited basis but that he still needed educational support.

Referral to the GMC FTPP

4.14 On 5 February 2010 the GMC informed Swindon PCT that following Dr Kandiah's performance in the Test of Competence he was to be referred to the GMC Fitness to Practise Panel (FTPP). It was stated in that letter than in response to the GMC's Rule 7 letter Dr Kandiah had stated that he remains disappointed by the outcome of the recent test of competence and that he questions the relevance of some of the questions he was asked. In the opinion of the GMC this response cast doubt on whether Dr Kandiah has insight into his performance as it was clear that he rejects the findings of the recent test of competence. Undertakings had not been agreed by Dr Kandiah.

Findings of the GMC FTPP

4.15 The panel sat on 5th November 2010. They considered Dr Kandiah's performance in the August 2009 Test of Competence, the 2006 NCAS assessment, the 2007 GMC Performance Assessment and Dr Kandiah's training programme. The circumstances of Dr Kandiah's performance in diagnosing, recording and treating patient H's diabetes was not placed in evidence before the FTPP. The team leader and medical assessor said that the low

score in the test of knowledge was of concern, but that in their view Dr Kandiah was capable of improvement and that he would not be a risk to patients, provided there was supervision.

4.16 The FTPP concluded that on the basis of the findings of the test of competence his professional performance has clearly been deficient. They considered documentary and oral evidence on steps taken to remedy the deficiencies including evidence from Dr Ballard that he had made improvements in a number of areas. It accepted he had insight into his deficiencies and that he had taken real and significant steps to rectify them, but it was concerned with his low score in the test of knowledge and was not satisfied that had been remediated. They concluded that his fitness to practice is currently impaired by reason of his deficient professional performance.

4.17 The panel considered sanction and concluded there was no evidence of general incompetence, that he had demonstrated insight into areas of concern relating to performance, that there was evidence of a potential and willingness to respond positively to retraining, patients would not be put in danger, and conditions will protect patients. All these findings were made without knowledge of or reference to Dr Kandiah's performance in relation to Patient H. It imposed 14 conditions on Dr Kandiah's practice, including supervision and regular meeting with an educational supervisor.

Patient H

4.18 Patient H was a registered patient of Dr Kandiah from 2002 until 2010. On 10 December 2007 a random blood glucose test indicated a reading of 6.7 mmol/L. It seems that this reading was obtained by a locum practising at the Sparcells Surgery. The reading was referred to as being high blood glucose and he was given life-style counselling. On the 12th February 2008 another high blood glucose reading, this time of 7.4 mmol/L was obtained, again, by a locum practising at the surgery. Patient H has a family history of diabetes, as his father and grandfather are suffers. According to NICE guidelines, a reading of 7.1 and above is an indicator of diabetes and further investigation should be undertaken.

4.19 According to Patient H, in February and early March 2010 he began suffering from excessive thirst and excessive urination. He was drinking up to 5 litres of fluid a day and having to urinate every 2 to 3 hours. He was not sleeping well, feeling tired and losing weight. These were all new and unusual symptoms for him, and he was very concerned about them. Mrs H, in her evidence, also described these symptoms and how Patient H's disturbed sleep also woke her. She encouraged her husband to see the doctor and it was she who made an appointment for the 10th of March. There had been no discussion between them about any testicular problem, or diabetes. One concern had been the possibility of prostate cancer, another was urinary tract infection.

4.20 On March 10th 2010, Patient H saw Dr Kandiah about his symptoms and Patient H was very clear that during this consultation he described these symptoms fully. He said no testicular examination took place on that day and he was merely advised to see if the condition improved over the following week. Mrs H confirmed that Patient H made no

mention of a testicular examination by the doctor on the 10th March. Patient H accepted that he had had a testicular consultation but not on 10 March 2010.

4.21 The symptoms continued and worsened. On Wednesday 17th March 2010 he attended work but felt so ill that he went to the surgery and tried to secure an urgent appointment. He said he was about to pass out and could not concentrate. He was told by the nurse that the earliest appointment available was the 19th March. Patient H was feeling so unwell that he attended the local walk-in centre. He again described his symptoms to the nurse who immediately performed a finger prick test and measured his blood glucose. The reading indicated a blood glucose level of 20.9 mmol/L. The nurse telephoned Sparcells Surgery and obtained an appointment for 4.30 pm that day. She also sent a fax to Sparcells recording Patient H's visit, setting out the symptoms he described, and the blood glucose level, and mentioned a family history of Type 2 diabetes.

4.22 Patient H returned home and called his wife who was at work in Nottingham. Mrs H was so concerned that she left work immediately and drove the 180 miles home so she could accompany her husband to the consultation. Mr and Mrs H arrived at the surgery where there were other patients also waiting for an appointment with Dr Kandiah at 4.30. Dr Kandiah saw Mr and Mrs H in a consultation lasting for just 3 to 4 minutes.

4.23 At the beginning of the consultation Dr Kandiah had difficulty accessing his computer and the receptionist had to assist him. Both Mr and Mrs H were clear that a full description of Mr H's symptoms was given to Dr Kandiah at this time plus the fact that there was a family history of diabetes. They said that Dr Kandiah's response was that Patient H possibly had diabetes, but that he required a starvation blood test to confirm the diagnosis.

4.24 According to Patient and Mrs H, Dr Kandiah told them, while they were in his room at the surgery, that this could not be done until Friday, 19th March as there was no nurse available on Thursday the 18th March. Mrs H questioned him further as to when the results might be available and as to what would happen next, and if any further tests were necessary. Mrs H stated that Dr Kandiah's response was, "I can tell who wears the trousers in your house." Mrs H was angry and upset at this remark.

4.25 It seems at some point there was mention that the nurse at the walk-in centre had referred to diabetes insipitus. Dr Kandiah's response was, "They don't know what they're talking about." Mrs H felt this was being dismissive of the walk-in centre staff. When Mrs H arrived home after the consultation she made notes about what happened at the surgery.

4.26 On Friday 19th March Mr and Mrs H arrived at the surgery and the starvation blood was drawn. Testing of the blood indicated a blood glucose level of 24 mmol/L. Dr Kandiah was not present at the surgery, and Mr and Mrs H were dealt with by a nurse and a locum. In their evidence they expressed satisfaction with their treatment on that day. They were advised to as to what they might expect and to take the blood tests directly to the hospital themselves. The locum telephoned them at 2.00 that afternoon to advise them of the results which she had obtained herself from the hospital. They were advised to attend the Osprey

Unit at the hospital where a diabetic nurse spent nearly three hours going through information to assist Patient H and arranging insulin. Patient H was started on insulin that afternoon.

4.27 On Tuesday 30th March Patient H received a letter from Sparcells Surgery asking him to make an urgent appointment to discuss his blood test. This caused considerable concern to Patient and Mrs H. They believed the letter concerned some further problem other than the diabetes which by then was being treated appropriately. When Patient H attended the appointment on 1st April, Dr Kandiah asked what was wrong. Patient H replied that Dr Kandiah had asked him to come in to discuss the blood results. Dr Kandiah, after referring to his computer, said that Patient H was diabetic. Patient H was annoyed at the unnecessary anxiety he had been caused.

4.28 He was then asked by Dr Kandiah if there was anything else. Patient H raised the issue of cholesterol (which he had been advised about by the hospital nurse) and was prescribed statins. Patient H also mentioned that his eyesight had been poor for the last 10 days and asked to be referred for a retinopathy. Dr Kandiah did not reply to the request, but merely stood up and said goodbye. Patient H was so angry and annoyed that he walked out.

4.29 Patient and Mrs H sent a complaint to the Swindon PCT on the 23rd April 2010. Dr Elizabeth Mearns, a GP Trainer and a Fellow and Examiner of the Royal College of General Practitioners, and a practitioner at a medical centre in Swindon, was asked to investigate the complaint.

4.30 However she accepted she was not an expert on diabetes and also that not only had she carried out the investigation into the incident, but that she was a member of the Performance Screening Panel which had considered the case on the 21st June 2010, the Internal PCT Panel which considered the case on July 19th 2010, the Regulations Panel and the PCT Regulatory Panel which sat on 14th September 2010 and removed Dr Kandiah from the list. In these circumstances we did not place any weight on her evidence.

4.31 The patients records for Patient H retrieved from Dr Kandiah's computer indicated for the 10th March "*On examination – testicles normal right no red flag signs no testicular mass reassured review in 4 weeks Dr A Kandiah.*" Dr Kandiah accepted he had made this entry and further accepted that the entry did not report any symptoms or complaint. When it was put to him that Patient H was very clear that no such examination had taken place on the 10th of March Dr Kandiah said that Patient H was a very decent man who had better recollection and that he agreed with him.

4.32 There was also a reference in the patient's medical record for 10th March 2010 to "*Helicobacter pylori breath test*." Dr Kandiah said that this was an automatic electronic entry relating to a test carried out in hospital and in fact did not relate to Patient H. Dr Kandiah did not take any action to resolve this erroneous entry. There was no mention in the medical record for 10 March 2010 at all of Patient H describing symptoms of excessive thirst and urination, tiredness or loss of weight. Neither was there any reference to a diagnosis of diabetes or to any treatment or management of a diabetic condition. Dr Kandiah's account was that he did not accept Patient and Mrs H's account of events. He said Patient H did not

complain of these symptoms which would cause concerns regarding diabetes when seen on the 10th March 2010. At another point in his evidence he said he was not sure if they had been mentioned.

4.33 In the patient medical records for the 17th March it is noted there was a request for blood tests in glucose, haemoglobin and liver function tests. There is a reference in the records to "*tiredness symptom, bs very high about 28 mmol*". These entries were made by Dr Kandiah. There is a further entry for 17th March "*History obtained from third party. WIC sister rang did a bm 20.5 he has been feeling thirsty, apparantly (sic) he came in here and was happy to ring in the surgery tomorrow morning for an apt, following call from wic gave him an apt dl*" This entry was made by the receptionist after she had spoken to the walk-in centre. Dr Kandiah said that he had not read this entry at the time of the consultation with Patient H on the 17th March. Attached to the records was a copy of the fax from the walk-in centre. Dr Kandiah said he had not seen this either at the time of the consultation with Patient H on the 17th.

4.34 On the 17th March 2010 Dr Kandiah said that he had been attending a training session with Dr Wilson during the day and returned to the surgery at 4.30 to find three patients waiting. He was told that Patient H had been to the walk-in centre, and that a finger-prick blood test had shown a glucose level of 28. Patient H had eaten in the morning and Dr Kandiah's plan was to do a fasting blood test.

4.35 The consultation lasted about 4 minutes. He said the patient looked well, although he later accepted that he looked anxious. He said a fasting blood test was important to confirm the diagnosis of diabetes. There had been a number of misdiagnoses reported recently. He said in his evidence that Patient H did not mention excessive thirst. The patient medical record for 17 March only referred to excessive tiredness as having been mentioned on the 17 March. He accepted that to classify the blood test as non-urgent in the medical records was a mistake and it should have been marked urgent.

4.36 Dr Kandiah said that after the brief appointment on 17 March 2010, he asked Patient H to see the receptionist to make an appointment for the following day for the blood test. Dr Kandiah's account was that it was the receptionist who told Patient and Mrs H that the nurses were not available on the 18th March and that the appointment would be made for the 19th. He had not known about this. In the patient medical records for the 17th , apparently typed by Dr Kandiah, there was a reference in respect of the blood tests '*priority non urgent*.'

4.37 Both Patient and Mrs H were certain it had been Dr Kandiah himself who arranged the appointment for the 19th. We heard evidence that it was possible for Dr Kandiah to arrange appointments from the computer in his room. Dr Kandiah said that his remark about Mrs H wearing the trousers was merely an attempt to lighten the situation. Dr Kandiah said that the reference to the walk-in centre not knowing what they were talking about was in respect of the reference to diabetes insipitus.

4.38 The complaint by Patient and Mrs H, dated 23rd April 2010 was passed by the PCT to Dr Kandiah. He replied by letter on the 28th May 2010. Although that letter is addressed to

Mr and Mrs H at their home address, it was apparently sent to the PALS/ Complaint Service at the PCT and it was never received by Patient H and Mrs H. In that letter Dr Kandiah denied that Patient H had mentioned frequent urination and excessive drinking at the consultation on the 10th March.

4.39 Dr Kandiah also said in the letter that he had not referred to the walk-in centre "not knowing what they were talking about" on 17 March 2010. He also said in the letter of events on the 17 March 2010 "I did not feel that an urgent blood test was required as you only presented with tiredness, and you had no other symptoms such as frequent urination and excessive thirst." Later the letter said "When seeing the nurse on Friday the 19th March you presented with more severe symptoms, blurred vision, polyuria and polydipsia."

4.40 During the course of the hearing, however, Dr Kandiah produced two pathology request forms which he had completed on 17th March in which he requests the tests mentioned in the patient medical records. On those forms there is reference under clinical details to polyuria and polydipsia, that is to say, excessive urination and drinking; thus indicating that these symptoms had been mentioned by Patient H on 17 March 2010.

4.41 Dr Kandiah in his evidence in the hearing said that in writing his letter of the 28th May 2010 he had consulted the patient medical records. He said in the letter he had mentioned only tiredness because he said on the 17th March Patient H's symptoms were tiredness only. Excessive thirst and urination had only happened in the past. He later accepted in his evidence that Patient H had referred to excessive thirst and urination and produced the pathology request forms which confirmed this was the case.

4.42 It had not occurred to him on March 17th to test for ketones. Dr Kandiah said Patient H looked well. Professor Barnett a lecturer in diabetes, whom he had met, said that where a patient was really ill he should be treated straight away, but if he looked well and was relatively asymptomatic, the treatment he had carried out was appropriate. Of course on 10 and 17 March 2010 he was not in fact asymptomatic.

4.43 In his evidence Dr Kandiah said that Mrs H had referred to the walk-in centre as mentioning diabetes insipitus. He remarked that they did not know what they were talking about and that his diagnosis was for diabetes mellitus. He said that a non-fasting blood test such as the finger prick test might not be reliable as Patient H had eaten breakfast that morning and for that reason he had asked for a fasting blood test.

Use of Locum not on the PCT List.

4.44 John Reason, the Primary Care Development Manager for Swindon PCT said that on August 2nd he received notification of a complaint about a locum, Dr P, being employed at the Sparcells Surgery. Dr P had been removed from the Swindon PCT MPL in June 2010. Mr Reason said he telephoned the surgery and spoke to Ms Robinson, the practice manager, to inform her that any further sessions with Dr P should be cancelled. He said in his witness statement that shortly afterwards he received a telephone call from Dr Kandiah who he

understood to be saying had known the locum in question was no longer listed. Mr Reason asked for confirmation of the remark which according to him was given.

4.45 After the telephone call Mr Reason spoke to his director about the issue. It was put to Mr Reason that he had misunderstood what Dr Kandiah had said to him about Dr P, and that the reference by Dr Kandiah was to Dr P's training, and possibly to his inclusion on the GMC GP Register, but Mr Reason did not accept this. Mr Reason said in reference to the documents headed "Locum List for Wiltshire March 2010" that as far as he was concerned Swindon PCT does not use this list. He believed Wiltshire PCT used the list. Swindon PCT maintains a complete and updated MPL. Swindon PCT does not circulate names of practitioners who are removed from their MPL. He was not aware of any other practice that had employed Dr P inadvertently after he was removed from the MPL.

4.46 Dr Kandiah said that he had called Mr Reason on the 2nd August 2010. He had arrived at the surgery that morning to find Dr P, the locum, in attendance. He knew the doctor was not GP trained and this was frustrating to him as he was not allowed to practise while the locum was. He had checked with the practice manager at a surgery in Swindon and was told Dr P had been employed by them shortly before he had been employed at Sparcells. He was not aware that Dr P was not on the MPL.

4.47 When he spoke to Mr Reason, Ms Robinson his practice manager was present. He felt bitter about the locum being able to practise and it was this that the conversation was about. Dr Kandiah says he never said to Mr Reason that he knew the locum was not on the list. He could not remember Mr Reason asking him to repeat what he said. Dr Kandiah said his practice manager arranges locum cover for the practice and he had little to do with the process.

4.48 Ms Robinson, practice manager for Sparcells Surgery, said in her statement that she had engaged Dr P for 8 days in July 2010. She checked his registration with the GMC and spoke to the locum to confirm he was on the performers list for the Swindon PCT. She did not check with the PCT by telephone, but she did check a document headed "Locum List for Wiltshire, March 2010". This was a document compiled by Wiltshire PCT in conjunction with Swindon PCT which set out the available locums. She said this document was sent monthly by Mr Clarke's personal assistant at Swindon PCT.

4.49 Two copies of this document were produced to the Tribunal; both headed Locum List for Wiltshire, March 2010, but one was issued in June 2010 and the other in August 2010. The June version contained a reference to Dr P, while he was absent from the August list. Ms Robinson consulted the June list and concluded that Dr P was on the Performers List.

4.50 Ms Robinson stated that she had been present at a telephone call when Dr Kandiah spoke to Mr Reason about Dr P's training. She said this conversation had taken place in July, possibly several weeks before August 2nd 2010. On August 2nd she received the call from John Reason about Dr P while she was taking her son to football practice. She then proceeded to secure a replacement for Dr P. She did not recall sitting in on a telephone call with Dr Kandiah when he spoke to Mr Reason on the 2nd of August.

Dr Kandiah providing misleading information about the 2009 Performance Assessment

4.51 Paul Clarke is the Assistant Director of Primary Care Commissioning at Swindon PCT. At the end of 2009 he discussed with Dr Kandiah the outcome of the August 2009 GMC Test of Competence. He said Dr Kandiah told him the outcome of the test was fine (despite the fact the GMC assessors had found parts of this unacceptable and a cause for concern). It was put to him that Dr Kandiah had said that the Performance Assessment had not gone entirely well, but that there had been no alteration in the conditions imposed on him following the Performance Assessment.

4.52 Mr Clarke said he could not recall the details and could not be sure Dr Kandiah had said he had passed the exam, merely that the impression given was that things had "gone O.K.". He accepted that he was relieved that the PCT would not have to take action in relation to the surgery. He also accepted that following receipt of the GMC letter dated 5th February 2010 which set out in detail the results of the August Performance Assessment, he had not mentioned the matter subsequently to Dr Kandiah.

4.53 In his witness statement Dr Kandiah said that in a conversation with Paul Clarke he indicated that the Performance Assessment did not go well. He denied telling him that he had passed the Test of Competence.

Dr Kandiah's failure to notify the PCT of the GMC conditions.

4.54 In early 2010 Paul Clarke contacted the GMC about Dr Kandiah. On 5 February 2010 he received a letter from the GMC stating the GMC intended to refer Dr Kandiah to the GMC Fitness to Practice Panel (FTPP) because of inadequacies in his performance on the Test of Competence in August 2009, and the fact there were still concerns about the clinical performance of Dr Kandiah.

4.55 Mr Clarke said that he subsequently discovered that Dr Kandiah had been subject to conditions since January 2008. He said he would have expected that Dr Kandiah would have informed him each time the GMC conducted a review, particularly if conditions had been altered. The first time he had become aware of the conditions was in early 2010. He accepted that the GMC informed the PCT directly of the outcome of the IOP reviews, but this information was not passed to him until February 2010. Mr Clarke had come into his post in April 2009 and his predecessor had not informed him that Dr Kandiah was subject to conditions

4.56 On 31 August 2010 the GMC reviewed the Interim conditions and varied them. The conditions included a requirement to notify the conditions to the PCT. Dr Kandiah did not notify the conditions to the PCT until 20 September 2010.

4.57 Mr Clarke accepted that on the 19th February 2010 he had a telephone conversation with Dr Kandiah after a message was left with his son by Dr Kandiah. In that conversation

Dr Kandiah informed him of the outcome of the IOP review on 19 February 2010 and that the conditions were broadly the same as before.

4.58 In respect of the GMC IOP Conditions imposed on 4th January 2008, Mr Clarke accepted Dr Kandiah had notified the PCT on 10th January 2008. In respect of the IOP Review on 29th May 2008, Mr Clarke accepted that Dr Kandiah had notified the PCT by fax on the 4th June 2008. In respect of the IOP conditions imposed on 31 March 2008, 21 August 2008, 9 February 2009, 11 May 2009, the 3 July 2009, 9 September 2009, 29 April 2010, and the 3 July 2010 the PCT was not notified by Dr Kandiah of the result of the review by the IOP. On some of these occasions, for example 9 February 2009 the conditions had been changed, yet they were not reported and on 31 August 2010 the PCT were informed by Dr Kandiah only after a delay.

4.59 Dr Kandiah said in his evidence that he did not think it was necessary to notify the PCT where there had been no change in the conditions. He had delayed in sending notification in other instances. He accepted there was a condition to inform the PCT and that he had a duty under the 2004 Regulations to inform the PCT of material changes.

Dr Kandiah's failure to comply with the conditions imposed by GMC IOP on 31 August 2010 and 4 December 2010.

4.60 Paul Clarke said that Dr Kandiah has failed to comply with four of the conditions imposed by the GMC on 31 August 2010. These failures are set out in the GMC letter of 1st September 2010. These failures were firstly in relation to Dr Kandiah's obligation to provide a copy of Dr Wilson's report 14 days prior to the GMC hearing. The report was provided on the day of the hearing only as Dr Wilson had been away. Secondly there was a similar failure in respect of the report by Dr Kenny who had also been away. Thirdly, the FTPP noted that Dr Kandiah failed to inform the GMC of the proposed disciplinary proceedings by the PCT and fourthly, which was accepted by Dr Kandiah, there was a failure to complete the GMC Employer Detail Form, but that he was no longer working at this time.

4.61 In respect of the conditions imposed at the hearing of 4 December 2010 he had not appointed a workplace reporter because he was not working at the time (Condition 2). He had sent a personal development plan to the PCT 1 week ago (condition 6). He had kept in contact with Dr Wilson as an educational supervisor (condition 7). An assessment report will be compiled once a further assessment has been completed (Condition 10) . To undergo an objective assessment of knowledge he intends to sit the Applied Knowledge Test of the MRGP. But he has been told he has to be on a MPL to sit the exam (Condition 13).

4.62 Dr Kandiah is selling his practice. He says he would like to continue to practise part time for 2 or 3 days a week under supervision in a group practice, but not as a single handed practitioner.

Dr Kandiah's refusal to accept the findings of the Performance Assessment Team

4.63 In the minutes of the meeting of the Performance Screening Panel on 21st June 2010, Dr Kandiah was asked about the Test of Competency Assessment in August 2009. He stated

that he had challenged the GMC and needed to fight back as the questions he had been asked were not related to General Practice.

4.64 In the letter from the GMC to Mr Clarke dated 5th February 2010 it was said that Dr Kandiah in his response to a GMC Rule 7 letter stated "he remains disappointed by the outcome of the recent TOC (The Performance Assessment in August 2009) and he questions the relevance of some of the questions he was asked." The GMC concluded this cast doubt on any insight by Dr Kandiah as it is clear he rejects the findings of the recent TOC.

4.65 In his evidence to the tribunal he said he no longer challenged the results of the TOC "because he did not challenge things he could not change". He said later that many of the questions were relevant to doctors in hospital. At the GMC FTPP on 5th of November 2010 Dr Kandiah admitted the deficiencies in his performance in the August 2009 TOC.

References for D Kandiah

4.66 There are some 30 references and testimonials in the bundle produced for the GMC FTPP hearing from patients, colleagues and a nurse practitioner. He is referred to as honest, trustworthy, friendly, professional, helpful, kind, caring and generous. He is said to be accurate with his diagnoses, professional and a good doctor. He is referred to as courteous, dedicated, reliable, knowledgeable and supportive.

5. Consideration by the Tribunal

Dr Kandiah's performance in respect of Patient H

5.1 Dr Kandiah's case was that by 17 March he was aware of the significance of Patient H's symptoms, that he appreciated he may be diabetic and that he requested appropriate investigations on 17 March, including a fasting blood test. He said it was unfortunate that the blood test could not be performed the next day but Patient H looked well and did not appear to require more urgent intervention. Any failure was a failure to appreciate that more expeditious intervention was required. It was a single clinical incident. There is a conflict of evidence about the 10 March, but Patient H did accept he had a consultation about testicular pain albeit he does not accept it was on that day.

5.2 The case for the PCT was that Patient H had given clear evidence that he had supplied his full symptoms to Dr Kandiah on 10 March 2010, and that no testicular examination had taken place on that day. He was a fair witness who expressed sympathy for GPs. He said he had given his full symptoms to Dr Kandiah on 17 March 2010, which was apparently now accepted, although the patient records did not mention the full symptoms given or contain a diagnosis of diabetes although the tests requested on 17 March were consistent with this. The request for blood tests was marked non urgent. Blood was not drawn for two days. Dr Kandiah should have acted with greater urgency in commencing the diagnosis and management of the diabetes.

5.3 We considered the evidence with care. We noted how unusual, severe, pervasive and disruptive Patient H's symptoms had been in the run up to the 10 March, and that Mrs H had corroborated this evidence. Her sleep had been disrupted and we noted the appointment had been made by Mrs H specifically because of these symptoms. We noted that Dr Kandiah himself attested to Patient H being a very decent man "who had a better recollection".

5.4 We accepted that Patient H and Mrs H were good witnesses, generally both reliable and truthful, and we concluded that it was not possible that Patient H had attended the consultation on 10 March without giving Dr Kandiah a full account of these symptoms. We accepted Patient H's evidence about the events on 10 March and rejected Dr Kandiah's account. We therefore found that Dr Kandiah had entered an account of a testicular examination in the patient records for 10 March 2010 which had not occurred on that day.

5.5 We also accepted that Dr Kandiah had failed to notice or record the symptoms of excessive thirst and urination given by Patient H on 10 March 2010 and had failed to make a diagnosis of possible diabetes which we accepted ought to have been made as a result of those symptoms. We accepted he should have initiated tests and management initiatives on 10 March including blood glucose levels and ketone tests. We accepted that timely diagnosis, treatment and management of the condition was important.

5.6 We concluded that he had demonstrated significantly poor communication and listening skills with his patient, significantly poor diagnostic ability, that his record keeping and patient management was significantly poor during the incident and that his insistence on maintaining his account indicated a lack of insight.

5.7 We noted that that the conditions persisted and worsened for a week after the consultation culminating in Patient H feeling so ill on 17 March that he could not concentrate, almost passed out and had to leave work. This in turn meant that Mrs H had to leave work and drive 180 miles to attend the surgery. The failure by Dr Kandiah to make an appropriate diagnosis or commence appropriate treatment on 10 March 2010 caused patient H unnecessary discomfort and distress and his wife distress.

5.8 We also accepted that action should have been taken in respect of the helicobacter entry to ascertain its provenance and deal with the erroneous entry. We also accepted that some review or monitoring system should have been instigated by Dr Kandiah following the blood glucose reading of 7.4 on 12 February 2008, given the family history of diabetes and the NICE guidelines. We accepted this was Dr Kandiah's responsibility despite the reading having been taken by a locum at the practice, because Patient H was registered with Dr Kandiah.

5.9 In respect of events on 17 March we accepted that Patient H had again given a full account of his symptoms, including polyuria, polydipsia and tiredness, which now indeed seems to be accepted by Dr Kandiah, although there was one part of his evidence where this did not seem to be fully accepted by him. We noted only tiredness had been included in the

patient notes. We accepted that Dr Kandiah had made a provisional diagnosis of diabetes by the end of the consultation, although we noted that no mention was made of this in the patient notes.

5.10 We particularly noted that Dr Kandiah had specifically denied that on 17 March 2010 there was any mention of excessive drinking or frequent urination in his reply of 28 May 2010 to Patients H's complaint, confirmed by the fact that in the letter he had distinguished between that position on the 17 March and the position on 19 March when he said mention had been made of them. We did not accept Dr Kandiah's account given in his evidence to the tribunal, that what was being said was that tiredness was the main symptom on 17 March while excessive drinking and frequent urination had occurred previously. We did not think that was a possible interpretation given the wording in the letter.

5.11 We concluded that the wording in the letter was a deliberate attempt by Dr Kandiah to justify the fact he had marked the blood tests as non-urgent and had not sought the tests with sufficient urgency, when in fact he should have sought the tests more urgently. We did not accept that Dr Kandiah had "forgotten" the fact polyuria and polydipsia had been mentioned by Patient H on 17 March. The facts were too recent and the issue too central and important to allow for that. We concluded therefore that he had knowingly and deliberately sought to mislead the PCT on the issue, to whom the letter was sent. We also concluded that the account given to the tribunal that tiredness was the main symptom on 17 March was an attempt to avoid responsibility for the matter and showed a lack of insight.

5.12 We further noted that Dr Kandiah's patient notes for 17 March 2010, where he had referred to only tiredness, were inaccurate and incomplete, as was his failure to mention a diagnosis of diabetes. We accepted the account of Patient H and Mrs H, (consistent with the account in the complaints' email of 23 April 2010) that it was Dr Kandiah who had arranged the appointment for 19 March, knowing a nurse was not available on the 18 March. We accepted that Dr Kandiah should have initiated the testing, management and treatment of Patient H with greater urgency, given the symptoms, the high blood glucose level and the family history.

5.13 We concluded that on the 17 March there had been significantly poor performance by Dr Kandiah in securing a confirmed diagnosis, testing, treatment, record keeping and patient communication in respect of this incident as well as an attempt to mislead the PCT, and a significant absence of insight about the incident, both at the time of his response to the complaint and currently. There is, in our view, a risk to patients indicated by Dr Kandiah's performance in respect of patient H.

Dr Kandiah's current level of competence

5.14 The PCT's case is that the March 2007 and August 2009 GMC performance assessments showed a number of concerns about Dr Kandiah's clinical performance, including (in 2007) assessment, records and treatment and in 2009, knowledge base, which

was unacceptable, and diabetic control where there was cause for concern. Further Dr Kandiah's performance in respect of Patient H, which occurred after the 2009 assessment and involved shortcomings in the treatment of diabetes, suggested a continuing inability to perform at an acceptable level.

5.15 Dr Kandiah's case was that his extensive training programme in 2007 and 2008 had significantly improved his clinical performance. The PCT had ended his contingent removal on 14 November 2010. He had improved his clinical performance from the 2007 test to the 2009 test. While Dr Kandiah's performance assessment in August 2009 showed cause for concern in diabetic control, his overall performance in simulated surgery was acceptable at a score of 73.17%.

5.16 Dr Kandiah said the GMC assessors and Dr Wilson had indicated in the FTP hearing in 2010 that he had improved in a number of areas and had insight into his deficiencies. There was no evidence of general incompetence and he could respond to training. His case was that patient H was in respect of a single clinical incident only, and by 17 March he was aware of the possibility of diabetes and sought confirmation of it.

5.17 We considered the issue carefully. We noted that despite extensive and expensive retraining provided for Dr Kandiah there were still unacceptable deficiencies in his level of knowledge, and concern about his diabetic control and urethral syndrome, in the 2009 performance assessment. We noted that the 2009 assessment had specifically identified diabetes as an issue of concern. We noted from Dr Kenny's report of 19 April 2010 that Dr Kandiah had undertaken diabetes management training on 2 February 2010, (just 5 weeks before the incident on 10 March 2010) and a further course on new advances in diabetes management on 10 March 2010, and was still being seen by Dr Wilson and Dr Kenny at the time of the incident yet this had not prevented the poor performance of Dr Kandiah in respect of patient H.

5.18 We noted the remarks of the FTPP in November 2010 but these assessments were made without reference to his performance in respect of patient H. We have concluded that Dr Kandiah's performance in relation to patient H was significantly poor in a number of areas including the areas of diagnosis, record keeping and management. We do not think it is necessarily appropriate to characterise the handling of Patient H as a single clinical incident. We have found that there should have been monitoring of his condition following the raised blood glucose level in 2008. The shortcomings mentioned above were several in number and occurred on more than one day. His communication with, and management of, the patient and his wife were also poor. These shortcomings reflected many of the deficiencies reported in the 2006 NCAS and 2007 GMC assessments. There is, in our view, a risk to patients indicated from Dr Kandiah's current level of competence.

Dr Kandiah's state of knowledge in respect of the hiring of a locum who was not on the PCT's MPL

5.19 Dr Kandiah's case was that he had never told Mr Reason that he knew Dr P was not on the MPL, but that there was mention of a lack of GP training in respect of Dr P. The case for

the PCT was that he had said he knew that Dr P was not on the list. We considered the evidence carefully. We noted the evidence from Ms Robinson who said she had overheard a conversation between Dr Kandiah and Mr Reason about the lack of GP training for Dr P, albeit she though it was some time before 2 August.

5.20 We noted that on occasion Dr Kandiah's phasing and use of words could make understanding difficult. We noted also that Swindon PCT do not send to surgeries a definitive list of locums who have been removed from the list. We noted there was no apparent reason why Dr Kandiah should notify Mr Reason that he knew Dr P was not on the list.

5.21 We concluded that there was a possibility that Dr Kandiah had used inappropriate phrases and been misunderstood or misinterpreted and that on the balance of probabilities this allegation was not made out.

Did Dr Kandiah report the progress of matters relating to his GMC 2009 assessment to the PCT accurately?

5.22 We noted the evidence of Mr Clarke that he thought Dr Kandiah had said that he had passed the 2009 TOC, although he did say could not sure on the matter. We took into account Dr Kandiah's explanation that he had said the conditions had not been changed as a result of the Test, albeit the test had not gone well. We noted Mr Clarke had accepted he was relieved that he did not have to take action as a result, and that the matter had not been reopened after receipt of the letter of 5 February 2010. We concluded on the balance of probabilities that the allegation had not been proved.

Whether Dr Kandiah complied with his obligations to notify the PCT of conditions imposed by the GMC.

5.23 We accepted that Dr Kandiah had not always notified the PCT of the position as to the GMC conditions and had therefore breached the GMC condition to notify the PCT. Because on some occasions when there had been a change in the conditions, there had been either no notification or a delayed notification, we accepted the requirement in Regulation 4(3)(b) had also been breached.

5.24 We noted that the PCT had been sent the results directly by the GMC and that the procedures within the PCT had not ensured that Mr Clarke had been notified. Nevertheless the duty to inform was a personal one for Mr Kandiah and he had breached the duty on a significant number of occasions.

Did Dr Kandiah fail to inform the GMC that he was under investigation by the PCT.

5.25 This was admitted by Dr Kandiah.

Breach of GMC conditions

5.26 It was admitted that he had breached some of the conditions in inter alia failing to supply reports in a timely manner, albeit in mitigating circumstances.

Whether Dr Kandiah's continued inclusion in the MPL would be prejudicial to the efficiency of services.

5.27 We had regard to the relevant Regulations, to the 2004 MoH Guidance Document, to Kataria V Essex SHA and to the GMC Good Medical Practice set out above. We also took into account the proportionality of the issue and considered Dr Kandiah's rights to pursue his profession and earn income from it.

5.28 We concluded that Dr Kandiah's competence and quality of performance are such as to be prejudicial to the efficiency of services. Considerable resources in terms of finances, time and energy had been diverted to Dr Kandiah, but he continues to perform at a level in a significant number of areas which is below that required. There is, in our view, a risk to patients by his continued practice. Our concerns about his performance in the 2009 assessment and the treatment of Patient H have been set out above. Further we have found that he deliberately sought to mislead the PCT about the incident on 17 March 2010 in his letter of 28 May 2010, and we have also found he lacks insight.

5.29 His evidence to the Tribunal was on occasion contradictory and unreliable and we have rejected his account in a number of areas. We accepted that the PCT function in maintaining the MPL differed in a some respects to the exercise of the GMC function, including that "it is concerned principally with the interests of patients and the safety and efficiency of the service provided to patients". In any event the most recent GMC assessment at the FTP hearing in November 2010 was made without consideration of Dr Kandiah's performance in respect of Patient H. We concluded his continued inclusion in the MPL would be prejudicial to the provision of primary medical services.

Contingent removal

5.30 We considered whether the prejudice could be removed by imposing conditions under a contingent removal. We accepted that in considering this issue we must have regard to the proportionality of the decision to remove; that is to consider the effects on Dr Kandiah's right to pursue his profession and earn a living and the effects on patient safety and the efficiency of the service. We also took into consideration Regulation 12 of the 2004 Regulations, the relevant provisions of the 2004 DoH Guidance and the judgement in Dutt v Huddersfield which included a consideration of whether the appellant acknowledged the extent of his inefficient practice and whether the performer is able or willing to change.

5.31 We were invited to adapt the GMC conditions and also specify that Dr Kandiah could only work as an employed locum in a group practice on a part time basis. We considered this option carefully. We noted that conditions must be workable, measurable, enforceable and capable of removing the prejudice to the efficiency of the service. We concluded that Dr Kandiah's performance in respect of Patient H was so significantly poor, coming as it did after such an extensive and wide ranging programme of retraining, and while he was still being seen by Dr Kenny and Dr Wilson, that we did not think that any conditions could adequately remove the prejudice. We concluded that there was no workable condition,

including working part time in a group practice, which could supervise him adequately to ensure he would practise in a reliably safe manner.

5.32 Furthermore we have found that Dr Kandiah's insight is inadequate in several respects. We do not believe he accepts, to the necessary extent, the inadequacies of his practice. We did not accept that his remark that he no longer challenged the 2009 assessment because it was something he could not change showed adequate insight. We have concluded that he did not show proper insight into his performance in respect of Patient H. We do not believe that retraining or remediation of the inadequacies can be reliably attained by him.

5.33 We noted Dr Kandiah had knowingly given incorrect information to the PCT in respect of the incident on 17 March 2010. We agree with Burton J in *Kataria* that "*NHS staff and patients must be able to rely on the integrity of doctors and the honesty of their statements"*. For this reason, and because he had failed to report the position as to his conditions of practise on a significant number of occasions, he had failed to inform the GMC that he was under investigation by the PCT and he had failed to comply fully with some of the GMC conditions, we concluded that he could not be relied on to meet his responsibilities under conditions fully.

5.34 We gave every weight we properly could to Dr Kandiah's right to pursue his practise and earn a living, but we concluded that for the reasons set out above, no conditions, including those suggested on Dr Kandiah's behalf, could adequately and properly remove the prejudice to the efficiency of the service. In these circumstances we concluded the PCTs decision to remove Dr Kandiah from the performers list was proportionate and correct.

John Burrow

Judge HESC/PHL

11 April 2011