Case No. PHL/15305

TRIBUNALS SERVICE

FIRST TIER TRIBUNAL

PRIMARY HEALTH LISTS

Mr Christopher Limb : Judge
Dr S Ariyanayagam : Professional Member
Mr Colin Barnes : Lay Member

B E T W E E N:-

DR MUHAMMAD FAZLUL HAQUE
GMC REG NO 1732531

Applicant

NEWHAM PRIMARY CARE TRUST

Respondent

DECISION

Introduction

1. We sat to hear this case in London on 14th, 15th and 16th February 2011 and having completed the evidence and heard submissions, the members of the Tribunal further met on 17th February to reach our decision. In addition to the substantial documents provided by the parties, we heard oral evidence from Dr Fine (expert witness) and Drs Joarder and Ruiz-Guitierrez called by the PCT, and Dr Silk (expert witness) and Dr Haque called by the Applicant. In addition, we did, by agreement with the parties, read written witness statements from Dr Corlett (the PCT Medical Director who gave the general background of the investigation) and Dr Mailik. Dr Haque was represented by Mr Anthony Haycroft, Counsel, and the PCT represented by Mr George Thomas, Counsel and we were grateful to the legal representatives on both sides for their help in defining and to

an extent narrowing the issues in the case. We were also assisted by both opening and closing written skeleton arguments.

2. We were provided with a helpful written chronology by the PCT which was agreed to be accurate by the Applicant. Dr Haque qualified as a doctor in Bangladesh in 1964 and came to the UK in 1969. He began his GP training in Newham in 1980 and from 1988 worked as a GP in Newham. Until 2007 he worked in a single-handed practice. In 2007 Dr Joarder became a junior partner in the practice. For notable periods (and it appears to us that the precise dates do not matter) Dr Haque was abroad in Bangladesh from a date in 2007 until early 2009, but after 2009 he returned to full-time work in the UK and combined his own practice in Newham with out-of-hours work. The events which give rise to this case date from in and after February 2009.

3. Dr Haque suffered a stroke in 2001, but was able to return to work and it is to be noted that there was an occupational health assessment carried out in 2010 organised through NCAS which found no health impediment to work.

4. During 2009, concerns were raised as to Dr Haque's clinical competence, both in relation to his out-of-hours work and by his partner, Dr Joarder. The PCT considered those matters and in December 2009 Dr Haque voluntarily agreed to case practising. He was formally suspended from practice at the end of January 2010. On 16th March 2010 the Interim Orders Panel of the General Medical Council suspended Dr Haque for eighteen months. The PCT arranged a review of clinical records to take place, initially intended to be concerned with issues as to his prescription practices; Dr Fine undertook such review and in addition to

prescribing issues raised various other matters of concern. No other form of formal assessment of clinical practice was undertaken. Having received the report from Dr Fine, the PCT, at the end of July 2010, gave Dr Haque notification that they intended to consider his removal from the performance list at a hearing on 2nd September 2010. Neither Dr Haque nor legal representatives attended such a hearing and he was removed from the performance list at such a hearing. Such was formally notified by letter of 7th September.

5. Dr Haque lodged an appeal on 29th September 2010 and the PCT thereafter filed a formal response opposing the appeal.

6. The PCT hearing found that Dr Haque's continued inclusion in the Performance List would be prejudicial to the efficiency of services – namely an 'efficiency' case. The stated grounds were:

   (i) lack of clinical skill and history-taking

   (ii) failure to examine/investigate

   (iii) failure to combine history and examination into clinical management

   (iv) lack of evidence-based prescribing

   (v) lack of insight into own weaknesses and absence of self-reflection

   (vi) unprofessional attitude towards colleagues

   (vii) inflammatory and inadequate response to patient complaints

   (viii) failure to keep adequate clinical records.

7. By the time the matter came before us, it was accepted on behalf of Dr Haque in his written opening submissions that, although the issue is ultimately one for determination by this Tribunal, grounds for either removal or contingent removal

on the basis of efficiency are met. The practical difference between the parties at the hearing was whether we should uphold an unconditional removal or, alternatively, should order a contingent removal.

Law/Regulations

8. The hearing is by way of a re-hearing and we consider the merits of the matter afresh. Insofar as there are relevant issues of fact the burden is on the Respondent to prove the facts relied upon to the extent that we are satisfied, on a balance of probabilities, of their truth and accuracy.

9. The provisions of the National Health Service (Performance Lists) Regulations 2004 ('the Regulations') apply to the process of inclusion in a Performance List and relevant considerations for removal from such list.

10. Pursuant to Regulation 10(3) and (4), the PCT may remove a performer from its Performance List (*inter alia*) if his continued inclusion in its Performance List would be prejudicial to the efficiency of the services which those included in the relevant Performance List perform – an 'efficiency case'. When considering whether to remove a performer from its list in an efficiency case, the PCT should (*inter alia*) take into account the matters referred to in Regulation 11(6), namely the nature of any incident which is prejudicial to the efficiency of the services performed, the length of time since the last incident occurred and since any investigations were concluded, any action by any relevant regulatory or court body, the nature of the incident and whether there is a likely risk to patients, any failure to comply with a request to undertake an assessment by NCAS, (and

other matters not potentially relevant to this case). Pursuant to Regulation 11(7) in making a decision under Regulation 10 the PCT shall take into account the overall effect of any relevant incident and offences relating to the performer of which it is aware.

11. Pursuant to Regulation 12, the PCT may in an efficiency case decide to remove contingently, namely by imposition of such conditions as it may decide with a view to 'removing any prejudice to the efficiency of the services in question'.

12. At the request of the Tribunal, the parties expressly considered the wording of any conditions if it were to be felt that such were appropriate. It was thereafter agreed that appropriate conditions and wording would be:

(i) Dr Haque undertakes an enhanced learning needs assessment of his clinical and computer failings and performance assessment by the Deanery or the PCT or NCAS, as approved by the PCT (such approval not to be unreasonably withheld);

(ii) Dr Haque undertakes such clinical and computer skills retraining as identified by the assessment of (i);

(iii) Dr Haque undertakes such assessment of his performance as is identified as required by the assessment of (i) in a formal appraisal by the PCT;

(iv) Dr Haque's contingent status shall be reviewed by the PCT upon conclusion of his performance assessment at (iii).

Facts/Evidence

13. We heard evidence in relation to various cases in which it is alleged that the treatment or advice of Dr Haque was deficient and below an acceptable standard and therefore actually or potentially harmful to the wellbeing of patients and prejudicial to the efficiency of services. We also heard evidence directed to the issue as to whether Dr Haque has demonstrated sufficient insight so as to provide a basis for reasonable belief that he will both cooperate and approach potential relearning with an open mind as to his need for such retraining. Although there are differences of detail, there is no fundamental disagreement between the parties that both such matters are relevant.

14. The PCT also relied upon evidence of severe disagreements with and conflict with both Dr Joarder and Dr Ruiz, including actions to an extent amounting to threats and knowingly false allegations. Reliance is also placed upon the content of an annual appraisal which did not highlight any of the issues which, by the time of such appraisal in April 2010, had been highlighted. Mr Haycroft submitted that both such areas of the evidence did not help us in coming to the important decisions in the case whichever version of the facts were to be found to be correct; in effect, it was suggested that such evidence would not assist us in determining the extent of the deficiencies in Dr Haque's practice or his insight into those deficiencies. The PCT, in effect, argued that such matters are relevant because they demonstrate a character which is not such as to be amenable to open-minded assessment and potential retraining, but rather show an aggressive and confrontational approach to people who raise criticisms or with whom Dr Haque disagrees, or demonstrate lack of insight.

15. Having considered the matter we accept the approach of Dr Haque's Counsel in such regard. Whatever we decided upon the issues referred to in the previous paragraph would not, in our view, materially assist us in deciding the central questions of the extent of Dr Haque's 'inefficiency' or his insight into such and prospects of improving practice after assessment and retraining.

16. We therefore approach this case by considering and drawing conclusions in relation to the evidence which does or does not demonstrate deficient practice leading to actual or potential harm to patients and 'inefficient' practice, and/or which assists us in evaluating Dr Haque's insight into any failings.

17. Mr Haycroft submitted that it was not possible to determine the extent of inefficiency and particularly highlighted that Dr Fine accepted that the records review was not a satisfactory way of undertaking an assessment of clinical expertise and that some aspects are subject to the observation that it is not known whether any apparent deficiency is a deficiency in actual practice and care or a deficiency only in quality of record-making and keeping. We accept that it is not possible without a fuller form of assessment to know the full extent of Dr Haque's deficiencies, but we do not accept that some areas of deficiencies cannot be and are not properly considered upon the evidence in fact available. It appears to us that a fuller assessment might identify further areas for concern, but that there is already evidence – and in particular expert evidence – which identifies various examples in different areas of practice which are a legitimate source of concern and indicate sub-standard practice. It is noteworthy that there is very little difference between the two expert witnesses in the case and unless

we indicate to the contrary in this decision, the two independent experts agree in substance. We accept (and neither counsel suggested to the contrary) the agreed conclusions of the experts, both of whom gave their evidence appropriately and with evident care and objectivity.

18. The first cases to arise were the subject of expressed concerns or complaints either by patients (or parent of infant patients) or by other professionals in the context of Dr Haque's work out of hours.

19. The first case involved a 9 year old boy with a swollen, painful neck who was prescribed Diclofenac, but was also advised to use Ibuprofen, but not Calpol, if the pain was not controlled. The expert witnesses agree that Diclofenac and Ibuprofen should not be taken concurrently. Moreover, the Diclofenac was prescribed in the form of 50mg tablets, but advice given to break those tablets in half and to give 25mg on each occasion. The tablets are enteric-coated in order to protect the stomach lining and the experts agree that the breaking of tablets both removes such protection and also gives rise to the likelihood of an incorrect dose. Moreover, tablets are available in 25mg form. We accept that this incident demonstrates a lack of knowledge of appropriate practice in relation to prescribing which carries risk of some harm to the patient albeit probably not risk of serious injury.

20. The second case arising in the course of out-of-hours practice arose from Dr Haque's prescription of Metronidazole for a 2 year old boy with diarrhoea. The experts agree that Metronidazole is not the appropriate initial treatment for diarrhoea (in the absence of indication of causes rarely encountered in the UK).

The correspondence following the complaint also demonstrated that Dr Haque believed that Metronidazole was an anti-fungal and anti-helminthic – both experts agree that such is simply wrong. Both experts indicate and we accept that the use of Metronidazole in such a way is not the appropriate treatment for diarrhoea and moreover that Dr Haque has a misunderstanding of the nature of the drug for which there is no objective logical support. His oral evidence indicated that he used the drug because he used it successfully when treating patients in Bangladesh. It may or may not be that the specific bacteria for which Metronidazole is effective may be more prevalent in Bangladesh, but such is no proper basis for its routine use for diarrhoea in the UK. It is another example of Dr Haque having an inappropriate approach to prescription of medication. It is not likely there would be positive harm as a result, but the treatment was not likely to be effective.

21. A third case arising from a complaint in the course of out-of-hours work related to a prescription which was given in the wrong name and, moreover, was for a bronchodilator in syrup form as opposed to inhaler form. The complaint also concerned Dr Haque's general behaviour and in particular his use without explanation of dark glasses and potentially poor communication skills. The experts both indicated that mistake as to the identity of the patient (Dr Haque saying that a different patient entered the surgery to the one whose name was called) is wrong, but can on occasion occur. We do not place great weight upon this aspect. There was agreement between the experts that it was inappropriate to use bronchodilator in syrup form and such is contrary to current guidelines which indicate use of an inhaler. Furthermore, the experts agree that he demonstrated poor communication skills and that such are not simply a matter of

politeness but of clinical importance. The case is a further illustration of the failure to act in accordance with widely available and recognised accepted prescribing practice.

22. The fourth of the out-of-hours cases concerned a lady in her 50s with chest/breathing problems. In addition to a relatively minor criticism as to the frequency with which Prednisolone should be taken there was agreed criticism of the prescription of a bronchodilator in oral form (Bricanyl) as well as a bronchodilator inhaler (Salbutamol). The case is a further illustration of a failure to follow widely accepted guidance and practice as to prescribing in relation to a fairly common condition. The case is also an illustration (to which we shall refer later) of inappropriate response to the concerns of the pharmacist when the prescription was presented.

23. There were various cases brought to the attention of the PCT by Dr Joarder. We refer only to those in which there was criticism agreed by Dr Silk.

24. The first case involved a prescription of Pseudoephedrine in a dose of 30mg three times per day for a 3 year old child. The British National Formulary (BNF) indicates a prescription of 15mg every four to six hours for children between the ages of 2 and 6 and a 30mg dose for children between 6 and 12 years. The dose prescribed was plainly contrary to the recognised guidance and no individual justification for the particular patient was given. (Dr Haque made a broad reference to the dose being related to body mass index, but we did not understand this to be a serious contention that a child of only 3 had the equivalent of the average body mass index of a 6 to 12 year old child.)

25. The second case involved the prescription of Simvastatin in the context of a recorded history which, in the opinion of Dr Silk, revealed no clear reason for starting such a drug. It is at the very least an example of very poor records to the extent that there is no indication as to why the drug was given: the various test results actually available and recorded did not justify the drug.

26. The next example was a further case of prescription of Metronidazole for diarrhoea of short duration. The same comments apply as in relation to the previous Metronidazole case.

27. The next case involving agreed criticism concerned a 71 year old man given Amoxicillin (which contains penicillin). The allergy template within the computerised system clearly includes a record of the patient having an adverse reaction to penicillin. The case is a further example of inappropriate prescription of medication without appropriate consideration of factors relevant. Although there is no indication the individual patient suffered a serious consequence, there is a potential for serious consequences in such circumstances.

28. The next case involved two quite separate concerns. A lady who wished to lose weight temporarily for the purposes of appearance on holiday was, in the opinion of both experts, inappropriately given diuretics. The joint opinion is that diuretics are not appropriate treatment for weight loss and are certainly not so regarded by mainstream medicine. The same case also involved prescription of Carbamazepine (an anti-epileptic). Dr Haque indicated that this was a mistake and he intended to prescribe Carbocisteine (a mucolytic). Dr Haque told Dr Silk

that he recognised the mistake at the time and removed the Carbamazepine from the prescription (of which we did not have a copy), but failed to delete it from the drugs page. The agreed opinion was that there was no indication for either drug recorded. The patient provides a further example of inadequate clinical care.

29. The next case involved a lady aged 42 who had a presentation including shortness of breath. The experts expressed concerns both as to the failure to take appropriate steps to exclude a cardiac cause and treatment including Aminophylline which can be linked to palpitations and arrhythmias. Dr Silk moreover gave the general opinion that the paucity of information in the records made it difficult to identify much logic in the prescribing pattern employed.

30. Drs Fine and Silk jointly considered the appropriate conclusion to be drawn from the record review in a broad fashion. By way of introduction it should be noted that the record review carried out by Dr Fine involved the review of fifty-two sets of medical records which were randomly selected and represented 2.5% of the patient list. The overall written conclusions of Dr Fine in his report included the paragraph:

> "*The evidence of the record review demonstrated clear failings in Dr Haque's clinical decision-making with his routine management of patients being many years behind the times in terms of the use of evidence-based medicine and current clinical guidelines. This seemed to be particularly the case in a number of specific clinical areas, including asthma, upper respiratory tract infections, mental health and change in bowel habit.*"

He did however give the proviso that some of his comments depend upon records that were frequently inadequate in their content and level of detail. In his written report Dr Silk concluded that in addition to clear deficiencies in use of the computer and recording, "*… there is evidence that the doctor, in some aspects of his care, is sticking to an approach that fails to take into account evidence-based medicine and current clinical guidelines for appropriate GP management.*" He listed examples of giving antibiotics too readily for sore throats and URTIs, antibiotics on the basis of telephone consultations, Metronidazole for diarrhoea, statins without proper regard to cardiovascular risk charts, bronchodilators in tablet form instead of inhalers for asthma, Montelukast without first giving first and second line asthma treatments a proper chance, and Prednisolone in divided doses rather than as recommended in a single dose.

31. In the joint statement, Drs Fine and Silk agreed that the records indicated failures in relation to examination. Dr Silk in particular draws attention to the fact that this may or may not be due to a failure to make recordings of history in fact taken in examinations in fact made, but Dr Fine was of the opinion that because of the numbers of examples it is more likely that there was actual failure. For present purposes, we proceed on the basis of Dr Silk's view. But in such a context we do note Dr Fine's observation that if in fact the failing was a failing to record a full history in fact taken or an examination in fact undertaken, then the degree of failure in relation to the record is even greater and the consequence in relation to lack of information for any subsequent doctor seeing the patient the greater. The experts moreover agreed:

> "*The records show little evidence of a coherent or rational approach to diagnosis… There are some areas where (treatments that are*

inconsistent with best practice or evidence) has been shown to be the case. Examples are asthma treatment and Metronidazole for diarrhoea."

They agreed that the poor standard of note-keeping showed he was not then safe to practise as a GP and the review of out-of-hours cases together showed clinical issues that Dr Haque needs to address in order to reach a satisfactory standard of care. Such matters included the management of asthma and diarrhoea. Dr Fine also expressed particular concerns in relation to mental health and gastrointestinal problems.

32. Drs Fine and Silk agreed that computer training itself would only directly address note-keeping deficiencies but not clinical skills. They agreed that the extent to which Dr Haque could be trained within a reasonable timescale would depend upon his willingness and ability to learn and to acquire new information and skills. If further assessment and retraining was to be undertaken it was agreed that the time needed for any training would depend upon the full extent of shortcomings that were revealed by the fuller assessment. There was express agreement (albeit such is probably more an issue for the Tribunal than for the experts) that "*If he does not have insight and has difficulties maintaining professional working relationships with colleagues, further training is likely to fail.*"

33. There are other aspects of the evidence relevant to the issue as to Dr Haque's insight and factors affecting the prospects of success for any retraining. In such regard we consider not only those items of evidence which concern his previous behaviour when issues of potential deficiencies have been raised, but also his evidence before us. We preface our remarks by noting the clear statements by

him in his witness statements and through his Counsel that he accepts that there are matters which require to be addressed and that he is willing and would like the benefit of further assessment and retraining. It is important for us to assess the evidence as to whether such is in practice a true position.

34. Dr Haque on many occasions tended to start to answer questions before the question was complete and then spoke at great speed and at great length. We make the assumption that that is an aspect of his personality and style rather than a matter of substance; and we concentrate upon the substance of what he said. In such a context there do, having considered his oral evidence, appear to be only a very small number of matters which he unequivocally accepted as criticisms of his practice. He accepted that Diclofenac is available in 25mg tablets and that he did not know such and he accepted that he should not have been advising breaking of a enteric coated tablet. At one stage he appeared to accept unequivocally that he was at fault for not heeding there was a record of the patient who was allergic to penicillin, although he then added that it may have been (albeit not recorded) that the patient had had penicillin-based medication subsequently and without adverse reaction. At one stage he also appeared to unequivocally accept some criticism in relation to the patient (one of those referred by Dr Joarder) who had shortness of breath.

35. We summarise evidence relevant to Dr Haque's present and likely future approach to acceptance of shortcomings in his practice and willingness to learn. He has over the last couple of years been to various events giving him continuing professional development hours. They were relatively few in number, but more specifically it appeared after he gave his evidence (as well as from looking at the

certificates themselves) that he had simply gone to whatever courses were available locally and without charge, rather than in any way attempting to find courses addressing the areas of practice which had been the subject of concerns or criticisms.

36. We were concerned that upon many occasions in the course of his evidence Dr Haque – having said that he accepted the criticisms made by the experts and in particular those by Dr Silk instructed on his behalf – firmly disagreed in his evidence with the expert views and in particular the expert evidence of Dr Silk. We were also concerned that upon various occasions he appeared to in one form or another blame someone else for a mistake which had been agreed by the experts to be an example of his own sub-standard treatment.

37. We deal with matters broadly in the order in which they arose in the course of his cross-examination.

38. One of the cases arising from out-of-hours practice concerned a complaint by a mother relating to treatment for her son who had had a sore and painful neck. In a letter of 11th June 2009 Dr Haque indicated that he had reviewed his management and wrote the letter in order to hopefully resolve the issues. It was considered in the out-of-hours service and in particular by Dr Nasralla, Clinical Governance Lead, that his letter did not fully address the complaint and it was suggested that Dr Haque might review the facts more carefully and pass on his response. In cross-examination Dr Haque suggested that the fault lay with Dr Nasralla who should have intervened. When considering the substance of the inappropriate concurrent prescription of Diclofenac and Ibuprofen he answered

by referring to checking upon compatibility of the medications in sources such as the BNF as 'paraphernalia' and gave us the impression that he thought such matters were not a sensible use of his time but rather that he should simply be giving painkilling medication to a patient in pain without any wider considerations. At one point he expressly suggested that the issue of compatibility did not apply to the particular patient if they had unbearable pain.

39. When dealing with the complaint which included a mother's complaint that Dr Haque was wearing sunglasses, yawned throughout the consultation and appeared rude, Dr Haque appeared to still think it was appropriate to respond in his letter on the basis of what he thought was a joke by referring to himself as 'old and ugly'. He appeared to have no understanding even by the time of the hearing that there was a serious complaint as to his behaviour which he should address in a serious manner.

40. When considering one of the out-of-hours cases in which the experts had jointly agreed that it was inappropriate to be giving bronchodilators in oral form and in particular when an inhaler was also being given, he repeated in clear terms (despite his earlier indication that he accepted criticisms from the experts) that "*I think I was right*." He appeared to have had gained no insight into the issue raised despite it having been the subject of agreement between the experts and being one of the cases highlighted in the course of preparation for and in the course of this hearing. The approach he had taken towards the pharmacist who identified the issue, was a written response that the pharmacist was "*very rude and overpowering… he was showing off his knowledge.*" He gave no indication in the course of his evidence that he regretted such approach and indeed

(despite the experts having in effect agreed that the pharmacist's concerns were correct), emphasised that the pharmacist was of little experience whilst Dr Haque had great experience.

41. Dr Haque was taken in cross-examination to the experts' joint agreement in relation to the inappropriate use of Metronidazole for diarrhoea. Despite having had his attention drawn to the agreement (including Dr Silk), he expressly said "*But I was right for this particular person.*" He appeared to be adamant that he would treat the patient in just the same way today despite the observations of the independent experts. Moreover, he did not even accept that he was wrong in referring to Metronidazole as an anti-fungal or an anti-helminthic. Having been asked about what was indicated in the British National Formulary and what Dr Silk was saying, he repeated that he disagreed with Dr Silk.

42. He was cross-examined as to the use of a diuretic for weight loss. He straightforwardly and unequivocally said he disagreed with Dr Silk and did not agree that diuretics were not recognised for weight loss in mainstream medicine.

43. He was referred to the case raised by Dr Joarder in relation to the patient with shortness of breath and to the opinion of Dr Silk in his report. When he was asked if he agreed with Dr Silk's view having read it, he said clearly that he did "*not agree.*" He expressly disagreed with Dr Silk's views that from what was written there was little logic.

44. At the end of his evidence and in answer to a question from a member of the Tribunal, he said in very clear terms that he could not change his view as to the

use of Metronidazole for diarrhoea nor of its properties as anti-fungal and an anti-helminthic. He said "*It is the best drug*."

Findings

45. There is agreement between the parties that the ground of inefficiency is established. We have nevertheless considered such issue independently. In the light of the clear and reasoned conclusions of the experts, we have no hesitation in agreeing that the ground is made out. It is, moreover, a ground which established – as set out in earlier parts of this Decision – by reference to numerous areas of practice. It is not restricted to a particular patient or a particular condition. It may be that a fuller assessment would give rise to further concerns, but the extent of proper criticism of Dr Haque's practice is already notable and covers various areas.

46. We have considered what both Counsel accept is the 'real' issue between them, namely whether removal should be subject to conditions so as to enable further assessment and retraining and thereafter return to practice if the retraining is successful. We have come to the view that such is not appropriate. It is in our view not reasonable or proportionate to so order. The evidence we have heard indicates that Dr Haque, even after the receipt of independent evidence including but not restricted to that of Dr Silk instructed on his behalf, is still in most areas of criticism unable to appreciate that he either is or even might be wrong. In various areas of which we have given examples, he confirmed that despite the agreed criticism of the independent experts he still believes he is right and in various examples expressly indicated he disagreed with Dr Silk. His oral

evidence confirmed and strengthened the conclusion that he would not approach assessment and in particular retraining with insight or an open mind.

Decision

47. We have read testimonials and letters in support of Dr Haque. We have no reason to doubt that Dr Haque has been very much appreciated by his patients over many years. There is no indication that until 2009 there were any complaints raised as to his practice. The cases which have occurred since the beginning of 2009 are, however, fairly numerous and impact upon various areas of practice. The failings are such that it is appropriate to find – and we do find – that the ground of inefficiency is made out. There is not, in our opinion, any proper base upon which to find that Dr Haque has insight into his failings or would approach assessment and retraining with an open mind: to the contrary, in almost all regards he holds to the view that he has practised appropriately even in cases where there is clear expert agreement to the contrary.

48. We dismiss the appeal and confirm that the sanction of removal from the Performers List is appropriate, proportional and reasonable.

CHRISTOPHER LIMB

22nd March 2011