IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY **CASE 13941**

Professor M Mildred - Chairman
Dr R Rathi - Professional Member
Mr AJ Lloyd - Member

BETWEEN

DR RAM SEWAK PRASAD
(Registration Number 2238870)
Appellant

and

MERTHYR TYDFIL LOCAL HEALTH BOARD
Respondent

DECISION WITH REASONS

Background

1. The appellant ("Dr Prasad") is a general medical practitioner who began work in the Merthyr district in 1983 and was in 1994 joined by Dr Satyendra Nath Jha ("Dr Jha") in practising from surgeries in Aberfan and Troedyrhiw in the district of the respondent Health Board ("the LHB"). After a hearing of a Performance Panel established by the LHB on1 October 2004 he was suspended from the Performers List ("the List") for one month during which he attended a computer training course and worked under supervision at an Advanced Training Practice for 11 days.

2. The LHB also referred Dr Prasad to the GMC whose Interim Orders Panel ("IOP") imposed six conditions on his registration on 8 December 2004. Those conditions included supervision by Professor Jonathan Richards or another medical practitioner nominated by the LHB. Dr Prasad gave undertakings to the GMC in November 2005 amended in May 2006 to take account of his transfer to salaried status on 1 April 2006.

Procedural history

3. On 31 July 2006 both doctors were suspended by a Reference Panel of the LHB. This suspension was extended by a different Panel of the FHSAA. Dr Prasad was suspended on the grounds of a significant risk to patient safety, major gaps in his clinical knowledge and failure to undertake any significant personal development. Dr Alan Cuthill was commissioned to investigate and report on these issues. In March 2007 Dr Prasad was given notice of a hearing on 2 April 2007. This continued on 17 May and 2 July 2007.

4. By letter dated 12 July 2007 Dr Prasad was informed of his removal from the List on the ground that his continued inclusion would be prejudicial to the efficiency of the services provided by those on the List. The letter referred to adverse findings in relation to record keeping, management of referrals, monitoring of prescriptions, failure to obtain consent and limited implementation of procedures, policies and protocols.

5. Dr Prasad appealed against this removal by a Notice dated 2 August 2007 on the basis of unfairness in the investigation and hearings, in particular that the LHB had unfairly withheld information relied on by it from Dr Prasad and his advisers, and that there was no explanation why removal, as opposed to contingent removal, was warranted. Directions were given by this Panel on 2 November 2007 for exchange of evidence and fixing the hearing to begin on 28 January 2008. It was ordered that this appeal be heard together with that of Dr Jha (Case 13942).

6. We were invited to rule upon the standard of proof to be applied to the burden on the LHB to prove its case in relation to the efficiency ground. By a decision dated 4 January 2008 we ruled that we were not bound by authority or the practice of any other regulatory body to

adopt a criminal standard and accepted that a fair balance of the competing interests rendered it appropriate that we should adopt a flexible approach to the civil standard of proof.

The hearing

7. The hearing took place at the Angel Hotel, Cardiff from 28 January to 1 February 2008. The LHB was represented by Ms Fenella Morris instructed by Messrs Morgan Cole and Dr Prasad by Mr Ranald Davidson instructed by Messrs RadliffesLeBrasseur. All members of the Panel confirmed that they had no conflicts of interest in hearing the appeal. It was accepted on all sides that the LHB should call its evidence first. Numbers in square brackets in this decision refer to page numbers in the hearing bundle.

The LHB's evidence: Dr Cuthill

8. The first witness was Dr Alan Cuthill, a GP from the Medical Centre, Taffs Well and a part-time investigator for the Primary Medical Care Advisory Team ("PMCAT") of the National Public Health Service for Wales. He was charged by the LHB with investigating the practices of Drs Jha and Prasad and he reported to the Reference Panel in July 2006. He was taken through his criticisms of the two Appellants by Ms Morris, beginning with those of Dr Jha and then turning to those of Dr Prasad.

9. Dr Cuthill withdrew a previous criticism of the treatment of patient KT in relation to her potassium levels. In the records for 13 March 2006 there was no reference to her low potassium level on 24 May 2005. The test should have been repeated for and mentioned at the medications review. There was no clinical record of the consultation on 21 March 2006.

10. The medication prescribed (Indipamide) was inappropriate according to guidelines of the British Hypertension Society ("BHS") which advise prescription of an ACE inhibitor or a beta-blocker in a patient under 55. The British National Formulary ("BNF") has a warning that indipamide can cause lowered potassium levels.

11. The Aberfan surgery notes had no case summaries – a standard GP requirement since the 1980s.

12. Patient JA was treated for a bloody discharge from a nipple with antibiotics and reassurance despite this being a red flag signal for breast cancer, especially in a patient with a strong familial history of breast cancer. Dr Prasad treated this as a case of mastitis. There was no record of an examination before referral to a consultant in May 2000. In addition there were no records of consultations at various appointments with Dr Prasad.

13. Dr Prasad's referral letter for patient AL to a breast surgeon was inadequately basic with no family history, no suggestion of urgency and no description of the duration of her symptoms. In fact she should have been referred on the pro-forma that would have ensured she would have been seen in two weeks. The consultant was clearly critical of the referral [1814].

14. Dr Prasad should have referred patient CM to a consultant dermatologist rather than making a partial excision of what turned out to be a malignant melanoma on 10 June 2005. Good practice required referral where, as here, the possibility of a melanoma was strong. His action could have damaged the specimen, was by an inappropriate technique and could have caused the disruption and even spread of the melanoma. Dr Prasad should have known all this from undertaking a minor surgery course with five-yearly refreshers. In addition there was no written consent or any note of an oral consent by the patient who was extremely lucky, in view of a referral delayed by over a year, that her melanoma had not developed further.

15. Dr Cuthill criticised Dr Prasad's monitoring of the thyroid function of Patient JG. He was treated with carbimazole, a thyroid suppressing drug, with no monitoring of his levels even though the medication review of 28 November 2005 should have picked this up. On this regime six-monthly thyroid function tests and six to twelve-monthly liver function tests are recommended by the NICE Guidelines. The fact that a patient is also under the care of a hospital does not relieve a GP of responsibility for his patient's care.

16. Dr Prasad sent Patient ME for four tests for thyroid function in April 2006 and changed her prescription without any analysis – if he had reviewed her compliance, he would have seen that she did not always pick her prescription up and was thus not taking the medicine he had prescribed.

17. Patient CP was prescribed Eumovate (a steroid) when Dr Jha misdiagnosed tinea vesicolor. The prescription might have made the condition worse and condition was described as recognisable by a medical student. Dr Prasad also saw her and failed to make the correct diagnosis. His knowledge of dermatology was below an acceptable standard for a GP.

18. Dr Cuthill reviewed ten consecutive patient records and formed the impression that Dr Prasad's notes were very skimpy and generally of an unsatisfactory standard contrary to the requirements of the GMC's Good Medical Practice ("GMP") to detail the patient's presenting symptoms and the findings with evidence of discussion of a management plan with the patient.

19. Dr Cuthill was of the view that chronic disease management was largely left to nurses with very little participation from either doctor and commented that there were no practice guidelines or protocols (other than two of an administrative nature). He described it as standard for practices to "tweak" national guidelines appropriately for local conditions and the approach of local NHS Trusts. These responsibilities remained, even if GPS became salaried.

20. Dr Cuthill asserted that Dr Prasad should have followed up the GMC action plan and adopted it into his own Personal Development Plan ("PDP") without waiting for an Advanced Training Placement ("ATP"). He could have used medical textbooks or websites, talked or sat in with local consultants or improved his areas of weakness. The GMC's GMP encourages reflection including clinical audit.

21. Dr Cuthill was pessimistic about the prospects for Dr Prasad's retraining on the basis there is no evidence he has acted on the advice of the LHB or the GMC or improved his practice between his first suspension in 2004 and his suspension in July 2006.

22. Cross-examined by Mr Davidson, Dr Cuthill said he had not been involved in preparing the Terms of Reference ("ToR") and had not clarified why there was no specific requirement to interview the GPs. He accepted that the ToR did not dictate who may and may not be interviewed. Although he knew Professor Richards had been involved in the supervision of Dr Prasad, he had not interviewed him because that was not in the ToR. He had interviewed clinical and other staff of the practice including locums in the course of his investigation.

23. Dr Cuthill said that he had measured Dr Prasad against the standards contained in the GMC's GMP despite using the use of the criterion "less than optimal" in the ToR [203]. He was aware that that was also the standard used in the GMC assessment whose details he had not seen but he was aware of the undertakings given.

24. Mr Davidson adopted the criticism contained in Mr Sutton's cross-examination in Dr Jha's appeal in relation to Dr Cuthill's failure to interview Dr Prasad (see paragraphs 22-26 of our decision in Dr Jha's case).

25. In relation to patient KT Dr Cuthill said there was an ambiguity because there was free text in the action box by Dr Prasad (which could not be subjected to an audit trail) saying "repeat 2 weeks". He had felt in the interests of fairness that he could not be sure that the patient had been mismanaged by Dr Prasad. Even though the incident was recent Dr Prasad would have been hampered in discussing the case with him because of the poor quality of the records. Dr Lock had been the duty doctor and had prescribed potassium supplements and Dr Prasad had actioned the PathLink result the next day. Dr Cuthill accepted that there was no entry in the appointments diary for 21 January or 29 March 2006.

26. In re-examination Dr Cuthill said that patients could come in without appointments [2143] and that it was possible that a consultation may not be entered into the appointments section of the computer records.

27. Dr Cuthill said that practice staff had brought up the failure to refer patients JA and AL although the incident with JA arose in 2000 outside the ToR. He accepted that there was no match in the records to show a consultation with Dr Prasad on 25 September 2000 and agreed that the referral of the patient to Dr Singh had been made by Dr Jha and not by the practice nurse. In re-examination Dr Cuthill confirmed there were two prescriptions of antibiotics [1256].

28. In relation to patient AL Dr Cuthill said that standard practice required a referral letter to include medical history and a summary of medication. He accepted there was additional information in the referral but said that it was of no clinical relevance. The family history and details of Dr Prasad's examination of the patient should have been included. Dr Cuthill did not accept the contention that reference in the letter to a "nodularity in the upper quadrant of the left breast" [1819] meant that an examination had been performed. There was no confirmation of the symptom in the records by reference to an examination.

29. In re-examination Dr Cuthill said that the purported history [1820] was a supplementary printout from the computer generated by a receptionist and that there was nothing there to help the consultant.

30. In relation to patient CM Dr Cuthill accepted that there was no evidence in the hearing bundle of a consultation with Dr Prasad in late 2003 although he said that he was told by practice staff that the manuscript notes for that period were incomplete. He agreed that the description of the patient's mole in the macroscopy section of the pathology report did not make it obvious that the lesion was a melanoma but there was reference [1929] to discolouration and pigmentation of the specimen.

31. In relation to the alleged absence of consent Dr Cuthill accepted that the patient had attended for excision of the mole nine days after Dr Prasad had asked her to come back for that purpose.

32. In re-examination Dr Cuthill said that there was no evidence of what the patient had been told and accordingly no informed consent to the excision. She should have been told that papilloma was a tentative diagnosis and of the different choices of treatment and told that because the mole was pigmented it needed to be treated expeditiously by secondary care. The choices to be described were GP or hospital care, cauterising the base and sending the lesion off for histology, an elliptical incision leaving a large scar and a shaving excision with the risk of leaving tissue behind and the risk of disseminating cancer cells by disturbing the melanoma. In fact none of these should have been options because the patient should have been referred. If the tissue was pigmented in the histology laboratory, it must have been pigmented *in vivo*.

33. In relation to patient ME Dr Cuthill accepted that his report dealt with a different concern from that raised in Dr Lock's incident report and that there was no record of the increase in thyroxine from 150 to 200 mgs but suggested that this was raised after the blood test on 24 April since the free text in the PathLink [1484] was to this effect. Dr Cuthill said he was able to discover the issue of the patient's non-compliance in taking the medicine and thus so should Dr Prasad have been able.

34. Dr Cuthill accepted that his criticism of the misdiagnosis of tinea vesicolor in patient CP did not match with his e-mail [3196] saying this was not a serious incident. He accepted that there was no record of more than one prescription of Eumovate although Dr Lock had described repeated courses of treatment.

35. In re-examination Dr Cuthill drew attention to the prescription of Eumovate on 5 May 2005 and that of E45 on 6 June 2005 and said it was very unlikely that the rash had changed significantly in the intervening month.

36. Mr Davidson adopted the cross-examination by Mr Sutton in relation to thoroughness, impartiality and quality of Dr Cuthill's report at paragraphs 22-26 of our decision in Dr Jha's case.

37. Dr Cuthill confirmed that the Practice Development Plan [340] is what he described as the GMC Action Plan.

38. In relation to Patient TE-R Dr Cuthill said that a doctor should record details of a telephone consultation and his management of the patient as standard practice.

Dr Waskett

39. The next witness was Dr Nigel Waskett, the Medical Director of the LHB since 9 June 2005, whose evidence of events before that date was based on reading documents and what he had been told by colleagues. He referred to the shortcomings identified in the Practice Development Plan at [348] and [358] and quoted the Clinical Governance Review of July 2004 [361] showing that there had been no significant input from the doctors.

40. He confirmed that the Action Boxes were part of the PathLinks system by which test results were sent electronically from the laboratory to the Practice. He said that the NCAA had said that the 2005 GMC investigation was appropriate.

41. He said that the assessment from Dr Jones of the Pontcae Surgery where the doctors had had eleven days training after their 2004 suspension suggested that they should establish a needs-assessment and a personal development plan ("PDP"); a GP had responsibility to identify his own practice development needs, even when salaried.

42. He described Dr Prasad's PDP [109] as quite inadequate referring only to improving computer skills and learning an injection technique, especially after he had received so much external advice. He drew the Panel's attention to the practice recovery plan [111], the restrictions on Dr Prasad's practice imposed by the GMC [140] and the unsatisfactory performance identified in the GMC assessment [387-411].

43. Dr Waskett told us that the concerns of the GMC were resolved by undertakings signed in November 2005 and amended, to take account of the change to salaried practice, in May 2006.

44. Dr Waskett said that it should be recorded whether a blood test had been done on a fasting patient to avoid ambiguity: good records were the foundation stone of good practice and it was vital to record both all relevant information and the advice given to the patient. A GP should be alert to the risks of not referring a patient with possible cardiovascular symptoms, particularly a middle-aged patient or a smoker since the disease was one of the commonest killers. A GP should persuade a reluctant patient to accept a referral: if an antibiotic is prescribed, it may suggest to the patient that he is merely suffering from an infection. If an antibiotic is prescribed, the patient should at the least be given an early appointment to return.

45. Dr Waskett said that a contingent removal was inappropriate since these doctors had been under scrutiny since 2003, had undertaken two action plans, undergone a GMC assessment, had training and supervision and become salaried doctors to relieve them of management responsibilities all to no effect: they were still not doing the basic things right.

46. To the suggestion that nothing could be done pending the AT required by the GMC Dr Waskett said that each doctor had a personal responsibility to maintain knowledge and skills and could not wait and rely on others. An acknowledged weakness in dermatology should not stop a doctor doing basic things such as checking blood test results, making appropriate records on the computer or obtaining consent. Advice could be sought from a specialist, if the doctor was unsure.

47. Cross-examined by Mr Davidson, Dr Waskett acknowledged that his comments on the period before his arrival at the LHB were hearsay, that the condition of the practice premises were the original concern, that there had been no NCAA assessment of the doctors, that Dr Prasad had not been suspended by the GMC, that Dr Prasad had practiced in Merthyr Tydfil from 1983 to 2004 and that he had had a good report from his training at Pontcae in 2004 [106]. He accepted that the GMC assessment looked at the safety of Dr Prasad's practice, that there was an overlap between the GMC consultees and Dr Cuthill's interviewees, that the appointment of a Practice Manager had resolved a lot of problems and that the GMC had described Dr Prasad as remediable.

48. Dr Waskett accepted that the undertakings to the GMC had not been signed until Professor Richards had given up his role and that Dr Prasad then had no educational supervisor but said that the doctors had responsibilities for themselves as individuals. He accepted that Incident involving Patient CP was accepted by the Review Panel on 28 July 2006 as not dangerous and that Dr Prasad had been unrepresented although he himself had not been in the closed session. He accepted that he thought suspension was a possible outcome but had not asked the Deanery what would be the effect of suspension on the proposed ATP. He said this was not relevant for the Panel whose main concern was for patient safety.

49. Although after suspension the doctors were in limbo they could have taken steps to help themselves. The Panel appointed Pamela Shephard-Stibbs to be Investigating Officer and she went to PMCAT for specialist help. Dr Waskett saw the ToR but could not recall discussing whether the doctors should be interviewed. He did not appreciate that they had not been interviewed when reading Dr Cuthill's report or when he himself made the recommendation that they fell irredeemably short of the necessary standard [919]. He accepted that Dr Prasad had not been interviewed during the investigation but not that Dr Cuthill had been biased.

50. Dr Waskett did not mention contingent removal in his report in view of the nature of the deficiencies and his belief that they would fall back into old habits even after ATP and that things had changed since the conclusions of the GMC assessment.

51. Re-examined by Ms Morris Dr Waskett said that the doctors did not need ATP to keep proper records, obtain consent, make adequately detailed referrals, stress the urgency of referrals or attend to blood results although they may have needed training in communication skills.

52. In reply to Mr Lloyd Dr Waskett said he had not been a Medical Director before and had no knowledge of ATP before he spoke to Malcolm Lewis at the Deanery thus he did not know that ATP was unavailable to a suspended GP. He changed his attitude to the case at the 28 July hearing and relied on Dr Cuthill to decide whether to interview the doctors.

<u>Professor Richards</u>

53. Professor Jonathan Richards said his opinion at [3194] that Dr Prasad may expect the LHB to solve problems was unchanged. The Practice Manager had been in post when he began his involvement with the Dr Prasad. He said that the Practice Manager exaggerated the progress made, for example the development of policies for repeat prescribing and thought that the condition of the Troedyrhiw surgery could be lived with whereas it was, in the opinions of himself and the GMC, unacceptable.

54. He described the document at [50A] as looking like a standard guideline produced by the LHB that should have been customised by the practice and document [50H] as adequate in respect of safety. The practice manager told him he had written [50I] as a basis for Professor Richards' work with the doctors. He saw [50J] a document of an untimed request for a home call with the time of its being passed to a doctor unnoted. He regarded [50H] as optimistic and said that during his involvement there were two or possibly three team meetings rather than monthly meetings. He did not recall seeing the list of Practice procedures [50O] or the house calls protocol [50Q].

55. In relation to [50U] there was no referral template and the existing referral letters fell well short of the GMC standard. He showed the doctors how to do it by means of the SIGN template and was upset and disappointed that, on audit a few months later, the template was not being used. He described failing to instal and use such a simple system as the straw that broke the camel's back. He said he would have expected a doctor worried about his future to want to improve and get things right and that he had "despaired" on seeing this failure.

56. He recognised that the doctors had served the community loyally for years and had their own styles but said the doctors needed to make changes for patient safety. He had told them that they did not have to do it all themselves: the Practice Manager, nurses and receptionists could all share the burden, but that this had not had any effect.

57. Cross-examined by Mr Davidson, Professor Richards accepted the problems were not confined to the doctors but said that Dr Cruise had focused on the other staff. He (Professor Richards) had shown the staff how he had changed his own practice using GMP and asking staff to think how they could help the doctors achieve the GMP standards.

58. He accepted that practice in the Valleys was very different and said the GMC assessors had unfairly taken one sentence of what he had said about Dr Jha's asthma management out of context. He said that his concern was whether the keenness of the doctors could translate into improved performance and that he had tried everything he knew to help them but that there had been no change.

59. Professor Richards said he was uncertain about what he could and could not do and was concerned that he should not act as an advanced trainer (which he was not) so acted as mentor: it was up to the doctors to implement the ideas he had suggested. He felt he could not go back and check on last week's lesson and that he was not helping the doctors attain the standard of practising safely. He gave them the number of a world famous communication skills school in Cardiff but they never took it up. They certainly needed ATP. He accepted that there was a sea-change in the skills needed by a GP, that the Practice Manager was not dependable and that it was not easy for the doctors to tell him to raise his game.

Dr Lock

60. Dr Terry Lock gave evidence that he was he was not aware of any protocols when he first joined the practice in March/April 2006 as a locum but there were verbal instructions given to the receptionists regarding repeat prescriptions. He had never seen the repeat prescriptions guidelines [50A]. He said the procedures for registration of under-16s, re-authorisation of repeat prescriptions and appointment slots were in place but that he had never seen [50O], the procedures for house calls [50Q]. In relation to clinical referrals [50U] he said that there were no secretaries in the practice and no templates on the computer. He remembered the incident regarding patient ME.

61. Cross-examined by Mr Davidson Dr Lock said that by the time of Dr Prasad's suspension he may have been working more than two days per week at the surgery. He said he had no educational responsibilities for the doctors nor any responsibility for improving their standard of practice. He did not see his role as supervisory.

62. When he received correspondence from the GMC regarding supervision of the doctors he wrote to them to clarify the position. He described himself as having a support role. He did discuss the difficulty of seeing which doctor had made an entry in the records and clinical incidents in a meeting with the doctors and Lesley Lewis. Asked whether the only meetings were those of 2 May and 25 July 2006, Dr Lock said he might well have discussed matters with the doctors over coffee but could not remember any specific dates. He accepted that there might be minor inaccuracies in his statement but otherwise stood by it.

63. He said that education might have helped Dr Prasad but that none was laid on by the LHB while he was there. He described the updating of policies and protocols as an ongoing process that does not happen overnight.

64. He was not aware that the incident of hypokalaemia of Patient KT was not being pursued and said he had discussed it with Dr Prasad "several days later" with Dr Prasad, perhaps over coffee.

65. On being shown the e-mail of 7 February 2007 [3196] Dr Lock said no-one from the LHB told him that some of the incidents he had reported were not significant. Asked about Dr Cuthill referring to his (Dr Lock's) misgivings about LHB support he said that he had felt that the practice lacked secretarial support and resources in connection with QOF work and quality improvement. He said that this had impeded overall efficiency, for example basic patient care items such as dressings were sometimes out of stock.

Ms Lesley Lewis

66. Lesley Lewis was the Head of Clinical Governance for the LHB. She explained that the clinical incident forms were part of LHB policy and that a pack was given to the surgery for the partners to adopt or adapt and the doctors were encouraged to use them to tell the LHB about clinical incidents. She confirmed that the LHB had managed the practice from 1 April 2006

67. When she received a report [248] from the Practice Manager regarding document storage by fax she spoke to him then met Dr Prasad. Jaine Griffiths, a nurse employed by the LHB and working at the Practice, gave her incident report E [251] by hand. She had not encouraged the submission of these forms. On 15 July 2006 she made an appointment to see the doctors on 25 July.

68. Ms Lewis was present at the interview with Dr Cuthill on 16 October 2006 when Patient JA said she had seen Dr Prasad many times including making a trip from Aberfan to Troedyrhiw because she did not want other people to know that she was going to the surgery. Dr Prasad thought it was an infection and so did not examine her. She was so alarmed that she went to the Aberfan surgery and on the way out saw the practice nurse who took her into her room, looked at her breast, discussed it with the doctor and instigated an urgent referral to Mr Braithwaite. Ms Lewis said she believed the patient who was adamant and quite clear although distressed. Ms Lewis felt she had no reason to doubt her.

69. Cross-examined by Mr Davidson Ms Lewis said that the appointment of 25 July had been arranged by telephone on 21 July 2006. The meeting on 2 May 206 followed the practice meeting and discussed how to deal with incident reports. Dr Prasad did not want the Practice Manager to be involved. Ms Lewis saw Dr Jha on 8 May 2006 but did not amend her diary log for 2 May. She agreed that the meeting of 2 May did not have the clinical incident reports and agreed that the April incident reports centred on health and safety concerns.

70. On 7 July Ms Lewis discussed the Practice Manager's incident report concerning record-keeping [230] at the Aberfan surgery and Dr Prasad showed her that he could work the PathLinks application on the computer. She showed him the incident form as was her custom and practice. If she had not taken the form to the meeting, she would have put bullet points in her diary to remind her of the items for discussion (and there were in fact none such in her diary). If they had not discussed the form, she would not have gone through PathLink.

71. Ms Lewis accepted that Dr Quirke reviewed all the incident forms and decided which should go into the bundle and said that Dr Prasad had not taken account of the whole patient but had rather just treated symptoms. She had not said anything to him about the possibility of suspension because she thought it was a matter for the LHB Panel and it was LHB policy not to mention it to doctors in advance. She went to see the doctors with Pam Wenger (formerly Shepard-Stibbs) on 28 July after the Review Panel. She confirmed that one of the new incidents on 28 July 2006 was Patient KT and that Dr Prasad had confirmed at the Reference Panel that he had not had time to review all the records. She confirmed that Pam Wenger had written the ToR.

Dr Prasad's evidence

72. Dr Prasad did not dispute that a finding of inefficiency was appropriate but sought an order for contingent removal with conditions equivalent to those imposed by the GMC and later turned into undertakings.

73. He began his evidence by confirming that the prescription to patient CP was E45 and not Eumovate. He told us he had stopped working at the hospital diabetic clinic when he was 65 and that he had had no disciplinary matters with the LHB before this. He described his practice population as having many deprived and unemployed patients with 32% elderly patients. He agreed with Professor Richards' about the mindset of patients in relation to public health and prescribing issues. The population was very stable.

74. In each surgery there were two receptionists and from 2004 a computer operator for input and scanning of data and two nurses employed by the LHB. Although there was great difficulty in recruitment there was a low turnover of staff. The Aberfan surgery was purpose-built in 1986 and the surgery in Troedyrhiw an old building. Both surgeries were owned by the partners and let to the LHB.

75. Dr Prasad referred to the practice development plan [340] in which he and Dr Jha tried to comply with all the recommendations of the GMC and LHB. The LHB helped in building a fence to protect the surgery against vandalism but provided no education or training. The practice manager tried to streamline the administration of the practice and organise multidisciplinary meetings [50A] and to produce guidelines which he kept. The nurses had protocols for the management of all chronic diseases although these were not in the hearing bundle. They were prepared by a team and some were developed from those in use at Taffs Well.

76. Dr Prasad said that the Clinical Governance review of July 2004 concluded that they had not met the targets of the Practice Development Plan although they had tried their best to achieve them and, he said, met them "except a few". During his supervised practice whilst suspended in 2004 he carried out surgeries then discussed cases and practice management with the supervising doctors.

77. Dr Prasad said the in accordance with the conditions on returning to his practice he saw Professor Richards fortnightly and discussed different topics with him including referrals, prescribing and record keeping. He began using the computer in early 2004 and had two weeks training with the LHB then enrolled on a course at Mid Glamorgan University for about a year. He did no advanced training as opposed to normal CPD and reading books.

78. He described the GMC assessment as exhausting and said it was the first time he had been examined since 1966. He saw the GMC report in November 2005 and agreed with the conclusions and recommendations and gave undertakings to comply with the conditions. When he became salaried in April 2006 he expected the LHB to provide a supervisor and pay for his ATP. He had no supervisor after Professor Richards.

79. He said he had no discussions with Dr Lock whom he found totally negative and who had a punitive attitude, never sharing incident reports with him. He met with Ms Lewis on 2 May, 7 and 25 July 2006. He showed Ms Lewis the PathLink and said he used to go through it first thing or after surgery every day he was at work. He had not seen the incident reports until six of them were in the hearing bundle that he was given on 28 July when leaving work. He did not discuss the hypokalaemia case (Patient KT) with Dr Lock. The Dean had told him he could not have an ATP whilst he was suspended and he informed the GMC of this. Dr Prasad produced [File 6] papers relating to his CPD.

80. Dr Prasad said that patient JA had never presented to him with a discharge from her nipple. If she had, he would have referred her urgently to a breast surgeon because it would have been a sinister symptom. He described his consultations with her for other symptoms between May 1999 and January 2001.

81. Dr Prasad said that he had advised Patient ME to stay on the same dose of thyroxine and claimed this was borne out by the prescription records. He was uncertain who had made the free text record of 24 April suggesting raising the dose to 200. If he had seen a high TSH level, he would have thought either that the dose was inadequate or the patient had poor compliance.

82. He described overlooking the referral of Patient GJ as a human error which he regretted. He did not refer the patient for a TFT test because he thought that was being done at hospital.

83. In relation to Patient AL Dr Prasad said that the referral letter would normally contain a family history and accepted that there should have been more content, that he had not completed the proforma and that the letter was not marked "urgent" although he had put "soon" at the top of the letter. He said that today he would use the fast track procedure and send a complete history. He said he had examined the patient's breast.

84. Dr Prasad believed he had only seen Patient CM on 1 June 2005 since he would have documented any other consultation as was his invariable practice. He thought it was a papilloma: a superficial nipple like growth on the skin arising from the mucous membrane. It was not red or pigmented. If it had been, he would not have asked her to come back the next week but referred her urgently. Not obtaining a written consent was a mistake. He told her that it needed to be excised and sent for histology; he told her what he was going to do. He had stopped doing minor surgery after this.

85. He said he advised E45 and did not prescribe Eumovate for Patient CP. He did not recall the nature of the rash but would recognise tinea vesicolor and prescribe a topical anti-fungal.

86. Dr Prasad accepted that he had failed to act upon the reading of 3.2 for Patient KT and that the test should have been repeated. He gave no prescription because the patient was asymptomatic. He agreed that an ACE should be prescribed, according to BHS Guidelines for a patient of this age but explained his choice to prescribe Indipamide, a diuretic, because it had a hypotensive effect at a low dose and that dose would not cause diuresis. He might have changed to an ACE, if the prescription of Indipamide had no effect.

87. Dr Prasad said that whilst awaiting ATP and since he had studied intensively, reading textbooks and journals and online materials and attended lectures. He produced [File 6] a file of his educational materials and said that he was definitely ready to comply with the GMC undertakings and wanted to have all restrictions on his practice removed in due course. He also confirmed that he had co-operated with Dr Jha on the clinical audits carried out in the practice.

88. Cross-examined by Ms Morris in relation to patient AL, Dr Prasad agreed that the fact of examination should be mentioned in the referral but that it was implicit in the letter. The letter was always accompanied by a computer printout from the records. He accepted that the family history of breast cancer had only been added to the records after the letter was written. He was unable to explain the delay in referral and agreed he should have written "urgent" rather than "soon". He could not say whether he had thought of using the cancer protocol. He was unsure whether the template for referrals advised by Professor Richards had been installed on the practice computer at that time.

90. Dr Prasad accepted that the consultant needed to know about the patient's family history of breast cancer; he had always taken a family history and was unsure whether it was entered on the computer. He accepted he should have mentioned it in the referral. He could not remember but thought the latter must have been posted, not faxed as it should have been, if urgent. The letter was addressed to Mr Braithwaite in General Surgery and Dr Prasad could not understand the reference at [1814] to "sending the letter to Medical Records". Asked whether he had chased up the referral Dr Prasad said that he could not recollect but would usually telephone the Department. He was adamant that his note referring to the upper left quadrant of the breast showed that he had examined her and said that the patient was lying, if she said he had not.

91. Dr Prasad accepted that he should have used the consent form before excising Patient CM's mole and that the Practice Manager had said in his progress report [50I] that this process was in place. He repeated that he told the patient that he was going to excise the mole and send it for histology. It did not cross his mind that it was malignant since it was neither crusty nor itchy, black or pigmented. He could only see that it was round. He told her

that he would use local anaesthetic but made no note of the conversation. He accepted that the mole came from the skin, rather than form mucous membrane as he had said in examination in chief. He gave up minor surgery because there were too many risks involved and this hearing was coming up.

92. Dr Prasad accepted that he did not refer Patient GJ to an endocrinologist and did not monitor the carbimazole because that was being done at the hospital: the patient was under hospital care and blood tests were being done there. He did not check the blood results when he did a medication review on 28 November 2005. He said that, looking back, he would have checked the results when doing the review and might ring the pathology laboratory to get the results. He would now write the referral letter the day he saw the patient.

93. In relation to Patient JA Dr Prasad said the prescription on 28 November 2000 was not in his handwriting: the patient may have complained of cystitis, the handwriting may have been that of the receptionist or he may have prescribed the antibiotic trimethoprim without a consultation. He was sure the patient did not present with a bloody discharge from her nipple: if she had he would have referred her. It was not his practice to prescribe trimethoprim for breast or soft tissue conditions or mastitis. He then said he might have prescribed trimethoprim but that there was no note of a consultation by him. He accepted that the patient may have told the receptionist that she had mastitis and asked for a prescription which was handed over whether or not there had been a consultation. Dr Prasad was adamant that he always recorded consultations and therefore that he had not seen the patient, even if the diary and appointment book suggested that he had.

94. Dr Prasad did not accept that he was unreliable at actioning PathLinks. He said that protocols were necessary to maintain standards of care, to review cases, to give guidelines how to deal with patients and to help monitor patients. He could not explain why he did not use the protocols that were in place to prevent his mistakes. He said that the LHB had taken over responsibility for protocols from the doctors and the practice manager on 1 April 2006 and the reason why Dr Lock was unaware of them was that the LHB had not told him where they were.

95. Dr Prasad said that a clinical audit was necessary to see how things were going in the practice. For example, they had found that 60-70% of those with Type II diabetes were on simvavastin and a year later this had risen to 90% owing to the practice policy. Professor Richards had not said which audits should be done but mentioned as possibilities home visits, anti-inflammatories and diabetes. Dr Prasad was not sure what a monthly prescribing audit suggested by Professor Richards [3168] meant although he ventured that this might mean a record of what drugs were being prescribed.

96. The audit of patients on levothyroxine [2481] was carried out under Professor Richards' supervision but Dr Prasad thought they had done a similar audit a year later. He said that Professor Richards had not given him the number for the communication skills course provider but then said that they had contacted the providers who were unable to help. After the GMC report he began the updating process for himself since the Deanery told him he could not do AT. He had never failed to record a consultation, even though the records may have been brief. He wanted AT with a view to going back into practice for as long as his health permitted. He did not mention retirement to Professor Richards.

97. Re-examined by Mr Davidson Dr Prasad said that he expected the failings identified by the GMC to be remedied through ATP.

98. On Patient AL Dr Prasad said that the referral template should contain a heading Family History. He would hand over the letter to the receptionist and ask for it to be posted or faxed. He attended Prince Charles Hospital on Fridays for a clinical meeting so would take letters by hand.

99. In relation to Patient GJ Dr Prasad said he must have asked whether bloods had been taken since he would have wanted to know what tests had been performed and the patient

told him that blood had been collected for a thyroid function test. Dr Prasad used to highlight what should be inputted into the records, if the material was unusual.

100. On Patient JA he said the surgery began to use computers probably at the beginning of 2004 and certainly not before 2003. He was not aware of any entries being made by others under his name. He did not think he and Dr Jha had involved others in the clinical audits. He became short of time for audits when preparing for the GMC assessment and then the LHB proceedings. He said that AT would help his recording. He had started recording notes on the computer in 2005 and prescriptions in 2004.

101. Dr Jha was cross-examined by Mr Davidson and confirmed that the computer was in use from 1999 for recording prescriptions; the receptionists were not very well trained and used to intermingle prescriptions and consultations so that it was highly possible that mistakes were made.

102. The evidence concluded in the middle of the afternoon of 31 January and it was agreed, in view of the delay inherent in fixing a further date convenient to all concerned, that closing submissions would be made sequentially in writing by 11 and 22 February respectively.

The LHB's submissions

103. The LHB put in 21 pages of closely argued submissions arguing that an outright removal was necessary in the public interest. The reasons in summary were said to be these:

a. the errors and/or failings of Dr Prasad were fundamental and inevitably exposed patients to risk, and, extending to so many areas of practice, that risk is widespread; the potential consequences of his errors and/or failings, some of which were realised in the cases of individual patients, were serious;
b. Dr Prasad's errors and/or failings were in areas of practice for which he was personally responsible as a professional, whether salaried or not, and whether subject to advanced training or supervision or not;
c. Dr Prasad knew or ought to have known what was expected from him in these respects: his weaknesses had been repeatedly pointed out to him by the LHB, NCAA, the GMC and other independent individuals such as Professor Richards;
d. Dr Prasad took no adequate steps to address the errors and/or failings that were drawn to his attention in the preceding years; in the circumstances, the prognosis now for the improvement of his professional skills to the necessary level is very poor, and such that the risk he poses cannot be adequately managed by way of conditions attached to an order for contingent removal;
e. Dr Prasad appears to lack insight into his errors and/or failings and is unwilling to take responsibility for them, preferring to blame the LHB and others for not providing him with sufficient training;
f. contingent removal is not sufficient to address the prejudice to the provision of efficient medical services, and in particular risk to patient safety and public confidence and therefore the Panel is asked to uphold the decision of the LHB panel to remove him from the List.

104. The LHB submitted that the regulations governing contingent removal require that any condition imposed must, in the view of the LHB and then the Panel, be sufficient to remove any prejudice to the efficiency of the services in that case. It further submitted that the issues in this case concern the public interest in the efficient provision of medical services. This includes patient protection, the maintenance of public confidence in health services, and the upholding of professional standards.

105. It further submitted that the GMC's guidance at the material time served to establish what was expected of doctors and that Dr Prasad knew or ought to have known what was expected of him. That guidance, GMP, issued September 2002 [5/68], required: (a) adequately assessing the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination, (b) providing or arranging investigations or treatment

where necessary, (c) taking suitable and prompt action when necessary, (d) referring a patient to another practitioner, when indicated, (e) keeping clear, accurate and contemporaneous records which report the relevant clinical findings, the decisions made, the information given to patients, and any drugs or other treatment prescribed and keeping colleagues well informed when sharing the care of patients, (f) keeping knowledge and skills up to date throughout the working life, (g) taking part in regular and systematic medical and clinical audit, recording data honestly, (h) where necessary responding to the results of audit to improve practice, for example undertaking further training; (i) responding constructively to the outcome of reviews, assessments or appraisals of performance, (j) taking part in confidential enquiries and adverse event recognition and reporting to help reduce risk to patients, (k) when referring a patient, providing all relevant information about the patient's history and current condition.

106. The LHB then made detailed criticisms of breaches of that guidance:

(a) record-keeping: no entries in the patient's records after consultations with KT on 24 January 2006 and with JA on 4 March, 5 October and 4 November 2005;
(b) failure to make appropriate referrals to secondary care and/or to follow up referrals effectively: after seeing AL on 20 June 2005, JA several times in 2000, CM in June 2005 (and carried out inappropriate surgery instead) , GJ in November 2005;
(c) failed to action abnormal test results and/or repeated tests unnecessarily and/or failed to test appropriately: GJ from September 2003, ME April 2006;
(d) failure to obtain CM's consent to surgery June 2005;
(e) inappropriate prescription to KT and inadequate medication reviews and repeat prescribing arrangements;
(f) unsatisfactory CPD and PDP, protocols and clinical audits;
(g) failure to rectify shortcomings between January 2003 and July 2006 despite help from the LHB.

107. In addition the LHB submitted that any criticisms that might be made of the quality and fairness of Dr Cuthill's investigation can only, on a re-determination, go to the cogency of the evidence: in many cases the facts are provable by documentary means. Any failure by the LHB to provide a practice supervisor as envisaged by the GMC was not causative of the errors that were within Dr Prasad's knowledge supplemented by a year's assistance from Professor Richards.

108. Contingent removal was inappropriate because:
(a) the failings are so basic that they indicate a fundamental "inefficiency" which is unlikely to be capable of remedy; (b) the nature of the failings and the risks they raise are serious and widespread, and this factor is relevant to the extent to which risk to patient safety can be adequately managed by the imposition of conditions; (c) such fundamental failings are not apt to be addressed by advanced training (and/or supervision), and therefore it is not realistic to submit that a condition requiring such training (and/or supervision) would lead to a significant change in the efficiency of medical service provision in the longer term; (d) the failings recurred despite a year of specific training and supervision by Professor Richards directed specifically to the matters for which Dr Prasad is criticised in these proceedings (as well as a history of previous input); any changes made were not sustained after he ceased to be involved and this leads to the inference that Dr Prasad is incapable of the change necessary to allow him, after further training and supervision, to return safely to independent practice and provide medical services efficiently; (e) Dr Prasad is unwilling to take responsibility for his failings, rather blaming others for failing to provide supervision and/or training, submitting that it was the LHB's responsibility to put things right and/or waiting passively for advanced training to be put in place; this lack of insight and responsibility is not a positive indicator for future change; (f) the prejudice to the public interest in this case outweighs any potential submission that individual doctors of the characteristics of Dr Prasad as set out above should be given yet another chance.

<u>Dr Prasad's submissions</u>
109. In connection with the standard of proof we were asked to be ready to adopt a standard approaching the criminal standard to reflect Dr Prasad's professional standing and value to his local community.

110. We were urged to be cautious in our acceptance of the impartiality and reliability of Dr Cuthill's evidence on the grounds that he did not interview Dr Prasad or Professor Richards, Dr Prasad did not have access to some documents relied on by Dr Cuthill who drew on comments made by Dr Prasad at the Reference Panel after inadequate time to prepare for it and that Dr Cuthill had included in his report the views of others.

111. Doubt was also cast on the credibility of Dr Waskett's evidence on the basis that he was unaware that Dr. Prasad had not been interviewed at the time producing his report for the purposes of the Reference Panel. We were also urged to give weight to the conclusions of the GMC assessment.

112. Dr Prasad's responses to the criticisms relating to individual patients were as follows.

KT: confusion in the Practice records and the unreliability of computerised records lead to the conclusion that the allegation that there was failure to record consultations on 24 January and 29 March 2006 cannot properly be regarded as proved. His clinical judgement was that the prescription of indapamide was appropriate, although not in accordance with national guidance.

JA: Dr Pra denied that she had ever in fact presented to Dr Prasad with a complaint of a blood stained nipple discharge and had first been seen for this by Dr Jha in November 2000. The fact that she had consultations with him in 1999 and 2000 (from the manuscript notes for entirely different conditions) is not proof of the allegation. Dr Prasad accepted that he failed to make a record of the consultation on 4 March 2005 but did not accept that he saw her on 5 October 2005 or 4 November 2006. The complaint to the LHB was seven years after the event.

AL: Dr Prasad accepted that his referral in June 2005 was not properly conducted and that he failed to act when the patient returned to see him in October that same year. He sought to explain this by saying that he had sent the referral the same day he saw the patient with a print-out of the records and that the print-out was fuller than that included in our Bundle (because in the latter family history is missing whereas the heading "drug allergy" is present but has no entries thereunder). He had asked for an appointment "soon" and added "early" in manuscript and the hospital was in part to blame for the delay. It was clear that he had examined her from his description of the "nodularity in the upper quadrant of the left breast".

CM: Dr Prasad denied he was consulted about the skin lesion before June 2005 when the growth was papillomatous and not pigmented and suitable for local excision. The lack of pigmentation is borne out by Dr Jha's record for 29 March 2004 and the macroscopic histological findings. Dr Prasad relies upon the consultant's comment that the skin coloured tissue was creamy but sought to explain away his other comments that (i) there was melanin pigment at the edge of the surrounding tissue on the basis that the hyperaemia/ redness could easily represent the effects of the excision surgery, (ii) the letter provided no clue as to how obvious the pigmentation was; (iii) the consultant's view was expressed roughly one month after the consultation by which time further changes to the appearance of the lesion may have occurred and the consultant's view was provided by a clinician with greater expertise and experience in such matters who has the benefit of knowing the histological diagnosis. Thus his actions were not inappropriate.

Dr Prasad accepted that he should have obtained the patient's consent for the excision but sought to mitigate this by saying that she knew about, had time to consider and agreed to undergo the procedure.

GJ: it was admitted that the referral letter was not completed and that he did not monitor the patient's thyroid medication. The latter was on the basis that he thought that this was being done by the hospital which did not ask him to check the levels and indicated that tests had been undertaken. The medication review had been undertaken before the letter from the outpatient clinic arrived.

ME: the action box was wrong: the dose of thyroxine remained at 150mcg and the test result arrived at the surgery after the medication review, thus there was no evidence of any inefficiency.

CP: not relied on by LHB.

113. We are asked to ignore general allegations relating to a register and care of housebound patients and of the terminally ill, arrangement of medication reviews and repeat prescribing arrangements on the basis that there was no forewarning of these allegations in November 2007.

114. Dr Prasad resists the allegation that his CPD, PDP and involvement in clinical audit were unsatisfactory on the basis of the documents disclosed in File 6, the conclusions of the GMC assessors, the disruption caused by his work with the GMC assessors and Professor Richards and his discussions regarding a change to salaried status and the effect of the delay in providing ATP. Dr Prasad acknowledged the need for help in developing these areas. The LHB disclosed clinical protocols (albeit late) and Dr Prasad believes that there were additional protocols not disclosed relating to the management of chronic diseases.

117. Dr Prasad accepts that his continued inclusion in the List would be prejudicial to the efficiency of the services provided by those on the List. He submits, however, that his removal should be contingent on conditions similar to the undertakings given to the GMC on the grounds that:

(a) it is incorrect to say that because some of the deficiencies in performance might be construed as being "basic" or "serious and widespread" or "fundamental", they cannot be addressed by advanced training or supervision as accepted by the GMC assessors and the GMC's Fitness to Practise Directorate;

(b) his failings have not been found to be resistant to training and supervision as alleged. Again the GMC's assessors found that Dr. Prasad's, "...staff and colleagues locally regarded him highly for his personable manner his willingness to acknowledge his identified deficiencies and to attempt to remedy them" [445]. This sentiment is echoed in the comments of (i) the practice which provided Dr. Prasad with 11 days of supervision in October/November 2004 [106-107], (ii) the former Chair of the LHB at the performers list hearing in November 2004 [118] - "impressed with their subsequent response with the support which had been made available") and (iii) Professor Richards in his evidence to the Panel and the note of Dr Prasad's improvement in the exhibit to Professor Richards' statement [3181];

(c) there has been no lack of insight on the part of Dr. Prasad to the deficiencies in his practise. He has readily acknowledged his failings to friends and colleagues, the GMC and to the LHB;

(d) whilst the LHB might argue to the contrary, *some* responsibility for *some* of Dr. Prasad's inefficiencies probably did lie with others. This has been recognised by Professor Richards in his evidence and witness statement [3163]. In addition Professor Richards was able to explain to the Panel the unique expectations which were imposed upon a GP working within a community in the Welsh Valleys and how these expectations might lead to performance issues considered inappropriate in other parts of the country. This was a problem of which Professor Richards had had first hand experience and which had taken his own practice 6 or 7 years to overcome;

(e) such assistance as was provided to help Dr. Prasad to remedy the deficiencies in his practice prior to his suspension on 31st July 2006 was piecemeal and incomplete. The LHB's response to the initial concerns about the performance of the Aberfan and Troedyrhiw surgeries in 2003 was to provide funding to assist with the construction of a fence around one of the premises. At the time of his suspension in October/ November 2004 Dr. Prasad was provided with only 11 days of supervision at a local practice. The supervision and support which was thereafter provided by Professor Richards, whilst undoubtedly successful in producing a number of improvements, did not provide the comprehensive and intensive programme of advanced training which had been planned to commence in September 2006. Professor Richards confirmed in his evidence that, in addition to not being an advanced trainer, his supervision of Dr. Prasad's performance was restricted by his inability to sit in on consultations and associated issues of patient confidentiality. Upon withdrawal of Professor Richards' supervision and support in November 2005, and despite the recommendations

made by the GMC and the agreement reached as part of the sale of the surgeries, no further advice, support, supervision or training was provided by the LHB. It is Dr. Prasad's case that even the contents of the significant incident forms (supposedly a tool to be used for self assessment and learning) were not shared with him by either Dr. Lock or Lesley Lewis until shortly before his suspension;
(f) the LHB's arguments ignore two key factors that reflect upon Dr. Prasad's overall abilities as a medical practitioner (past, present and into the future), the extent of the deficiencies in his performance and his capacity to successfully complete a course of advanced training. The more important of these is the doctor's unblemished disciplinary record over a working life which began in 1966 and which has seen him serve the same local community since 1983. Dr. Prasad is keen to undertake his retraining and return to clinical practice. Dr. Prasad's desire to complete his advanced training and return to practice is clearly evidenced not simply by his answers to questions posed in the course of the hearing, but by his continued attendance at post graduate lectures in 2006 and 2007 and by his decision to contest this case from the first performance review hearing in July 2006 through to this appeal. The decision on the part of Dr. Prasad (and Dr. Jha) to become salaried practitioners on terms which obliged the LHB to meet the costs of the advanced training is yet a further indication of the recognition given by both practitioners to the need for retraining.

118. Dr. Prasad's primary submission is that conditions similar to those undertakings given to the GMC [749-750] would remove any prejudice to the efficiency of services posed by the current shortcomings in his performance since numbers 1 to 7 and 10 to 13 provide for a programme of supervision and re-training specifically tailored to Dr. Prasad's needs which culminates in a reassessment of his professional performance. Such a programme has a number of obvious advantages, namely :
(a) because the concerns identified in the LHB's allegations largely mirror those identified by the GMC's assessors (assessment skills/ record keeping/ prescribing);
(b) there is every reason to believe that the programme is workable since no objection to its implementation or prospects of success was voiced by the LHB, the local GP Postgraduate Deanery or Dr. Prasad prior to his suspension;
(c) it provides for the dual safeguards of a workplace supervisor and an educational supervisor whilst the programme is ongoing. In this way any perceived risk to patient safety will be minimised;
(d) it provides for the additional safeguard of a reassessment of Dr. Prasad's performance before he is allowed to return to unrestricted clinical practice. By specifically requiring Dr. Prasad to submit to a further assessment of his skills at the end of his re-training any guesswork as to the potential benefits of the programme are removed and replaced by a decision based on his actual abilities at that time.

119. Dr. Prasad would be willing, if necessary, to submit to a series of modified conditions which precluded his return to work altogether (with or without a workplace supervisor) until he had completed his re-training and satisfactorily completed the reassessment of his professional performance.

Discussion and findings
120. We accept the criticisms of Dr Cuthill's and Dr Waskett's evidence referred to at paragraphs 110-111 above and take these into account when evaluating the evidence produced by the LHB. We do not propose to depart to the approach to the standard of proof referred to at paragraph 6 above.

121. We deal with the specific criticisms as follows.

122. Patient KT: we agree that there are discrepancies between the appointment records and the computerised patient records for 24 January and 29 March 2006. The records are the responsibility of Dr Prasad and his partner. We do not follow the reasoning concerning 6 August 2004: it seems that this appointment took place and (contrary to Dr Prasad's submission) it was the appointment of 11 February 2005 that was not kept. We conclude that the computerised patient records are probably correct and thus accept that no notes were made for these consultations. We consider that beginning with a prescription of Indipamide was inappropriate when an ACE inhibitor was the drug of choice. In passing we find it hard to

accept that Dr Lock could have discussed this incident with Dr Prasad "several days later" since the incident report was dated 27 July and Dr Prasad's suspension was on 31 July.

123. Patient JA: Dr Prasad clearly failed to make any entry for the consultation on 4 March 2005. We again find that the computerised record is more likely to be accurate than the appointment list and that it is probable that the patient was seen by Dr Prasad on 5 October and 4 November 2006. More important is the alleged failure to refer her for a bloody discharge from the nipple. There is no reference to this complaint in the manuscript records until the patient saw Dr Jha in November 2000 nor any record of prescription by Dr Prasad of antibiotics as alleged. The only contemporaneous evidence for the allegation is the letters from the hospital when she was referred in March 2001. These do not mention Dr Prasad by name although they are otherwise consistent with the allegation. The patient's complaints to the LHB were not made until 2006 by which time her memory would necessarily have been imprecise. In the light of these factors we are unable to accept that the allegation has been proved to the necessary standard.

124. Patient AL: Dr Prasad conceded that his June 2005 referral was not properly conducted. We find his attempts at paragraph 112 above to excuse this failure wholly unimpressive. We also find that his failure to follow up the request for over a year was far below the standards of good practice. We are unable to say with confidence that the patient was not examined.

125. Patient CM: in the light of the description of the macroscopic appearance of the excised tissue by the consultant histopathologist we find that Dr Prasad's failure to identify the melanoma was not below the standard to be expected of a GP. His failure to obtain consent to the excision was, however, a flagrant breach of an elementary obligation. We are again unimpressed by the excuses offered for it.

126. Patient GJ: Dr Prasad accepts that he failed to make a necessary referral to an endocrinologist and we find his explanation that it slipped his mind wholly unacceptable. We find that he was entitled to follow the lead given by the hospital departments that provided specialist care to the patient in relation to monitoring his chronic use of Carbimazole but consider that the medication reviews undertaken were insufficiently thorough.

127. Patient ME: Dr Prasad asks us to accept that the action box [1484] referring to increasing the thyroxine dose was merely "reflecting one alternative" course of action. That is not a natural reading of the text: on the other hand there is no record of a prescription raised to 200 mcg per day. This seems to us to be another part of a confused picture of uncertain practice and record-keeping. Dr Prasad should have noticed the compliance issue at the medication review and taken steps to ensure strict compliance thereafter.

128. Patient CP: it seems to us that this was at best a minor issue as the LHB now acknowledges.

129. We must be cautious in dealing with the more general criticisms made by the LHB. An advertised challenge to this at the beginning of the hearing did not materialise and it does appear to us that Dr Prasad has (in particular by the documents in File 6) put into issue his general standards of practice. We are unable to determine with precision issues relating to material not in issue before the LHB Panel because we have not been provided with a transcript of its hearings.

130. In relation to housebound patients we have not seen a register: Dr Cuthill's report deals explicitly with its absence. We have taken into account prescribing only in relation to the specific cases set out above. We accept that Dr Prasad's original Personal Development Plan was quite inadequate and find that Dr Prasad's attempt at clinical audit was limited and short-lived. We do not find that the pressure of a GMC assessment or change in employment status amounted to an excuse: attention to clinical improvement by the means suggested by Professor Richards and otherwise might have led to a less critical assessment from the GMC and thereafter, if integrated into the practice, genuine improvement in the quality of services delivered.

131. As already expressed, there are concerns over the quality of the evidence presented by Drs Cuthill and Waskett and we accept that Dr Lock may well have been seen by Dr Prasad as a Trojan Horse from the LHB more interested in finding fault than helping improve a difficult practice. It will be apparent from earlier parts of this decision both that we have in general treated the evidence called by the LHB with caution and that we have rejected some of the criticisms made of Dr Prasad's treatment of individual patients either on the standards applicable to GPs or on the weight of the evidence.

132. But all this must be seen from the perspective that Dr Prasad has admitted inefficiency in general and some fundamental errors in particular and the question for us is whether his removal from the List should be contingent.

133. Problems with Dr Prasad's practice emerged in 2003 and worsened in 2004. Supervised practice seemed to have helped but a GMC assessment found him seriously wanting. Dr Prasad had the benefit of a year's help from Professor Richards whose professional skill and humanity shone throughout his evidence. That evidence was only called by the LHB after Dr Prasad had alleged that the LHB had cancelled Professor Richards' brief to help him. We have no hesitation in accepting Professor Richards' evidence that he gave up in despair of getting Dr Prasad to change his professional habits.

134. To be sure, Dr Prasad was neither provided the supervision envisaged by the condition imposed by the GMC nor was he able to start the AT that he was expecting. The LHB's case is that matters were deteriorating fast and fundamental and basic errors were made that led to the conclusion that no AT would make Dr Prasad's practice independently sound.

135. The question for us is whether Dr Prasad's admittedly unsound practice is remediable? We heard him give evidence and our impressions of him were of a doctor who had given very long service to an extremely demanding community in difficult circumstances. The problem facing us is that Dr Prasad's practice appears to have slipped far behind the times and certainly not to have kept up with the requirements of GMP.

136. Although the case brought by the LHB was unsatisfactorily researched and presented in some aspects, there are two instances (Patients AL and GJ) where the care provided was simply inadequate. In the first an entirely unsatisfactory referral was compounded by failure to follow up to the severe disadvantage of the patient. This was despite the existence of an urgent pro-forma referral system that would have cured the defects in the referral and ensured an urgent hospital appointment.

137. In the second case all Dr Prasad could say was that the referral slipped his mind. That is just not acceptable in this century. We found him honest and sincere: his past achievements are, however, in danger of being spoiled by a failure to keep abreast of the times.

138. It is clear that modern aspects of record-keeping, computer use, practice organisation, systematic procedures (such as obtaining consent from patients) and clinical audit are matters in which he is clearly behind the necessary standards despite the help provided to him since 2003. In the light of this, and with reluctance, we do not consider that retraining for the extended period of training necessary and the obligation to pass an examination based on modern day practice would be a sensible option or one that would be likely to succeed.

Decision and Order

139. For the reasons set out above we are of the view that the appeal should be dismissed and we order that Dr Prasad should be removed from the LHB's Medical Performers List on the ground of efficiency.

140. We direct, pursuant to Rule 47(1) of the Family Health Services Appeal Authority (Procedure) Rules 2001 that a copy of this decision is sent to the Secretary of State, The National Assembly of Wales, the Scottish Executive, The Northern Ireland Executive and the Registrar of the General Medical Council.

141. Any party to these proceedings has the right to appeal this decision under and by virtue of Section 11 of the Tribunals and Inquiries Act 1992 by lodging notice in the Royal Courts of Justice, Strand, London WC2A 2LL within 28 days from the date of this decision. Under Rule 43 of The Family Health Services Appeal Authority (Procedure) Rules 2001 a party may also apply for a review of this decision no later than 14 days after the date on which this decision is sent.

……..
Mark Mildred
Chair of Panel
6 March 2008