IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY **CASE 13942**

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

BETWEEN

DR SATYENDRA NATH JHA
(Registration Number 2463195)
Appellant

and

MERTHYR TYDFIL LOCAL HEALTH BOARD
Respondent

DECISION WITH REASONS

Background

1. The appellant ("Dr Jha") is a general medical practitioner who in 1994 joined Dr Ramsewak Prasad ("Dr Prasad") 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 and Advanced Training Practice for 11 days.

2. The LHB also referred Dr Jha to the GMC whose Interim Orders Panel 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 Jha gave undertakings to the GMC in November 2005. In April 2006 Drs Jha and Prasad became salaried employees of the LHB.

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 Jha 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. On 8 March 2007 Dr Jha was given notice of a hearing on 10 April 2007. This continued on 22 May 2007.

4. By letter dated 6 July 2007 Dr Jha 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, clinical performance, delayed referrals and limited implementation of procedures, policies and protocols.

5. Dr Jha appealed against this removal by a Notice dated 2 August 2007 on the basis of unfairness in the investigation and hearings. 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 held together with that of Dr Prasad (Case 13941).

6. In November 2006 Dr Jha was suspended by the GMC for 18 months. The ground for this was a matter that, he argued, was not fully before the LHB hearing and thus could not, pursuant to Rule 41(7) of the Family Health Services Appeal Authority (Procedure) Rules 2001, be relied upon on the hearing of this appeal. We were initially of the view that such reliance was not

precluded by Rule 41(7) but were invited to review our decision under Rule 43(1)(a) of the Family Health Services Appeal Authority (Procedure) Rules 2001. By a decision dated 21 January 2008 we ruled that we would not hear evidence relating to the allegation referred to the GMC in November 2006.

7. We were also 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 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

8. The hearing took place at the Angel Hotel, Cardiff from 28 January to 1 February2008. The LHB was represented by Ms Fenella Morris instructed by Messrs Morgan Cole and Dr Jha by Mr Mark Sutton 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 evidence of the LHB: Dr Cuthill

9. 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 and began with those of Dr Jha.

10. In relation to patient MG there were three criticisms: failure to note a consultation on 20 June 2006, failure to make a clinical record of a prescription on the same date and an incorrect diagnosis of hypertension in breach of the guidelines of the British Hypertension Society ("BHS") rather than arranging investigations or referring the patient to a cardiologist.

11. Patient TE-R died of prostate cancer on 29 June 2006. There was a failure to record a telephone call asking for a home visit on 23 June 2006 and no reference in the notes of 16 March and 14 June 2006 (when Dr Jha had administered injections of Zoladex) to the patient's condition nor any cancer care review (which Dr Cuthill described as standard practice and part of the Quality and Outcomes Framework ("QOF")). Dr Cuthill said that Dr Jha's management of the patient was otherwise appropriate. A home visit would have enabled a doctor better to assess the patient's pain and the carers' needs. A prescription of Cocodamol was an inadequate response.

12. Patient DP presented with an irregular pulse. A chest X-ray was ordered but no ECG. Dr Jha thought there might be a chest infection and prescribed antibiotics. He should have been followed up in 48-72 hours. His reluctance to be admitted to hospital should have been dealt with by review after 48-72 hours by insistence or, at the least, by taking telephone advice from a hospital specialist. The patient had borderline blood sugar results and his potential diabetes should have been dealt with by referral for a glucose tolerance test.

13. Dr Jha did action the pathology results but did not follow them up a month later.

14. Patient DL had a blood glucose level of 9.6 (above the upper limit of normal of 6) on 31 May 2006 and a level of 7.3 14 days later. These results raised an overwhelming probability of diabetes but the patient was not contacted.

15. Dr Jha failed to refer patient CM on 29 March 2004. She told Dr Cuthill that she had told Dr Jha on that day that her mole was itching and changing colour (a clear warning signal for a malignant melanoma) and in those circumstances she should have been referred forthwith. If, as

Dr Jha maintains, she did not mention these matters, there would have been little risk in the delay. Dr Cuthill described Dr Jha's description of the mole as "fleshy" as unhelpful to colleagues as it is not a generally accepted medical term. The LHB later withdrew allegations in respect of this patient, presumably in consequence of our decision of 21 January 2008.

16. Dr Cuthill reported that Dr Jha appeared, according to nursing staff at the surgery, seldom to make intimate examinations of female patients. He gave as an example a prescription to a patient suffering pruritis vulvae without any record of an examination as unacceptable, given that this condition may have serious causes such as cancer.

17. Patient AL told Dr Cuthill that Dr Jha had not taken her blood pressure whereas the records show a measurement of 131/79 on 10 July 2006. Readings taken at hospital 17 days later showed 206/113 and a week later as 170/100. Dr Cuthill did not accept the first result but could not say whether it had been invented or was an operator or recording error.

18. Patient CP was prescribed Eumovate (a steroid) when Dr Jha misdiagnosed tinea vesicolor. The prescription might have made the condition worse and the correct diagnosis was described as recognisable by a medical student.

19. Dr Cuthill asserted that Dr Jha 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 admitted weakness in dermatology.

20. Dr Cuthill was of the view that chronic disease management in the Practice 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.

21. Dr Cuthill was pessimistic about the prospects for retraining on the basis there was no evidence that Dr Jha had 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 Sutton, Dr Cuthill accepted that he was not familiar with the Policy for LHBs on the Management of Performance Procedures [2346] or Guidance for LHBs on Local Procedures but agreed with the principles of openness, fairness to GPs, evidence-based enquiry, independence, transparency and a well-documented audit trail. Dr Cuthill asserted that he had tried to ascertain the facts in an unbiased manner and looked for exculpatory evidence, told the GPs the grounds on which he was acting and all the facts he was looking at. He accepted that this was the first occasion (out of ten investigations) on which he had not interviewed the doctors and justified this on the basis that it was not required by the Terms of Reference that he used as his instructions from the LHB: he had not thought it helpful or relevant to interview them and in previous investigations there had been a specific instruction so to do.

23. Dr Cuthill was taken to the first draft of his report regarding Dr Prasad which had ended with a recommendation that "All efforts should be made to delete their names from the performers List" [1056]. He said that he had removed this recommendation from the final report on his own initiative after a meeting of PMCAT advisers in February 2007 had agreed only to make findings (rather than recommendations). This meeting was independent of the LHB.

24. Dr Cuthill was unaware of any involvement of Dr Waskett (the LHB's Medical Director) in his report and did not remember the detail of an e-mail [3197] suggesting the contrary.

25. Dr Cuthill said that he placed no real reliance on the incident in relation to patient CP. It was not for him to criticise Dr Lock, the author of the incident report, to whom it appeared more

significant. He was taken to a passage in the same e-mail in which Dr lock was described as having serious misgivings about the support to the practice from the LHB and said he did not know about this: he did not regard the quality of the LHB' s support to the practice as a significant factor. He denied that he was not telling the Panel his full recollection.

26. Dr Cuthill accepted that it was important to keep full notes of interviews. He said he had kept many of them but had been told there was a difficulty in keeping and disclosing all his notes and had condensed them into his report. He said the next morning that he had only discovered the manuscript notes when he had been looking through the documents at the hearing. He accepted that he had not interviewed Professor Richards although his opinion was relevant to the question of remediability. He said that he had had many discussions with those working at the practice and with Dr Lock although he conceded that that was not a specific requirement of the Terms of Reference.

27. Mr Sutton then asked Dr Cuthill to deal with individual cases. On patient DP Dr Cuthill criticised the adequacy of the record which did not reflect good practice: it should have been recorded that the patient was advised to come in again or ask for a visit, if he was unwilling to be admitted to hospital in the first place. Dr Jha should have impressed on the patient the risk of a deteriorating heart failure; there was an urgent need for an ECG. Dr Cuthill did not accept that his understanding of the case would have been clearer, if he had discussed it with Dr Jha. In re-examination Dr Cuthill said that the advice to return or ask for a home visit should have been recorded in the notes but that such a course of action would have been inadequate in any event.

28. Dr Cuthill accepted that it was a Dr Jones, and not Dr Jha, who had misinterpreted an ECG and misdiagnosed patient DL and that he had missed this. He also accepted that he had made his criticism that Dr Jha had not actioned a blood glucose result on 31 May without looking at the action box (that showed that he had) and apologised for his error.

29. Dr Cuthill accepted that the prescription of Enalapril to patient MG on 25 November 2002 was probably by Dr Prasad but did not accept that this was the first prescription of Enalapril. He believed it was started by Dr Jha on 30 October 2002 and the prescription may have been made without a computer record. He did not believe discussing the case with Dr Jha would have helped five years after the event, given the brevity of the records.

30. Dr Cuthill said that a full examination was necessary despite the family history of angina and there was no documentation of the consultation. He maintained that the prescription of Simvavastin was wrong but accepted that it (and Enalapril) continued to be prescribed after Dr Jha had been suspended. In re-examination Dr Cuthill said that, if Enalapril had been prescribed for hypertension, the patient should have been brought back for a renal function test in two weeks and reviewed before the end of the 28 day prescription. He justified the continued prescriptions after Dr Jha's suspension on the basis that repeat prescriptions carry on after change of doctor until the patient's annual medication review in the absence of a consultation. In addition the blood test should have taken place 28 days after the prescription.

31. Dr Cuthill accepted, in the light of a faxed letter produced at the LHB hearing, that Dr Jha had referred patient TE-R but said that there was no cover sheet so that it was difficult to know exactly when the referral letter had been sent. He had withdrawn the allegation of failure to refer.

32. It was put to Dr Cuthill that the patient's daughter was asked to ring Dr Jha back, if her father was not better later that day. Dr Cuthill found this difficult to believe in the absence of any record. The use of Macmillan Nurses may be appropriate but it is the responsibility of the GP to coordinate the patient's care.

33. Dr Cuthill was sceptical about the blood pressure reading of patient AL documented on 31 December 2004 since the records document a complaint by the patient of a cough on that day for which a blood pressure reading would be unusual.

34. Dr Cuthill said that there were no practice protocols available to him during his investigation although he accepted that several had been since disclosed.

35. At this point the LHB conceded there were no specific allegations regarding housebound patients although the absence of a register was criticised in general.

Dr Waskett

36. The next witness was Dr Nigel Waskett, the Medical Director of the LHB since 9 June 2005 whose evidence 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.

37. 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.

38. 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 PDP; a GP had responsibility to identify his own practice development needs, even when salaried.

39. He described Dr Jha's PDP [110] was quite inadequate referring only to learning computer skills and 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 his practice imposed by the GMC [140] and the unsatisfactory performance identified in the GMC assessment [548-558].

40. 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.

41. 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.

42. In relation to patient TE-R Dr Jha should have gone to assess the bony spread of the disease and consider referring him for a bone scan and to assess the pain and appropriate pain relief.

43. 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.

44. To the suggestion that nothing could be done pending the AT required by the GMC Dr Waskett replied 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.

45. Cross-examined by Mr Sutton, Dr Waskett accepted that one must be unbiased and alert to all exonerating features but did not accept that interviewing the doctors had been necessary. He recalled Dr Cuthill saying that the reason he had not interviewed Dr Jha was that the latter was in India and agreed that NCAA could have been involved. He accepted that the LHB Panel on 23 November 2004 had been impressed by the doctors' response to the LHB process and that the GMC had required that they be given 18 months supervision.

46. Dr Waskett accepted that the GMC had found Dr Jha receptive and considered that his practice was remediable and that the appointment of the Practice Manager had been helpful although the appointment had not been successful in the long term. He said, however, that both doctors would go along with the process but not follow up changes back at the surgery and that it was not in his power to procure AT which was for the Deanery to procure.

47. Malcolm Lewis of the Deanery had spotted that the doctors could not work alone together because of the GMC conditions so the LHB had arranged for Dr Lock, a salaried GP, to work in the practice and provide cover when the doctors were at training. He accepted that the GMC had required supervision by a workplace supervisor [68] and that the GMC said that it had agreed with the LHB that Dr Lock would be that supervisor and that by this time the doctors had become salaried.

48. Dr Waskett responded that from his point of view Dr Lock was a watchful GP checking that the practice was as safe as possible. Neither he nor Dr Lock had seen that letter from the GMC. The primary reason why the doctors had been offered a salaried position was to relieve the heavy burden of management on a two-partner practice and to help them get back on track.

49. He accepted that the GMC had stipulated an educational supervisor and a practice supervisor and responded that Dr Lock was fulfilling two functions: covering the doctors when they were on training and keeping an eye on things. He said that Maria Thomas of the LHB referred to Dr Lock as a "supervisor" [1148] because that was the term used by the GMC. He himself thought Dr Lewis would keep a watchful eye while the LHB paid for the doctors to be retrained. He pointed out that the GMC had also referred to support for the practice, rather than supervision [163]. He pointed to his letter to the Deanery on 14 June 2006 relating four clinical incidents as flagging a teaching need as evidence that the LHB was still trying to get the doctors back on track.

50. It was put to Dr Waskett that the LHB had suddenly withdrawn its support for reasons of expediency and owing to the difficulty of finding Dr Jha a training placement. Dr Waskett acknowledged that there were different opinions in the LHB but said that as the evidence of the clinical incidents came in opinions changed. Dr Quirke had said that the cases must go back to another Review Panel and the matter had then been taken out of his hands.

51. At the Review Panel on 28 July 2006 no ATP was in place and there was no educational supervision; Dr Waskett did not agree that the LHB had failed to provide practice supervision. He accepted that NCAA had wanted to be actively involved but could not remember exactly when he had talked to them. He said he had been taking advice from ore experienced people and some had recommended he should speak to NPSA so he did.

52. Dr Waskett said there had been two changes from the time he had recommended ATP: more clinical incidents had occurred and there had been a meeting between Drs Jha, Prasad and Lock and Lesley Lewis and it was considered that Drs Jha and Prasad were not taking responsibility for their actions. Dr Waskett accepted that in this period there was no specific incident alleged against Dr Jha.

53. At the end of the Panel on 31 July Dr Gill Todd had suggested that it would be useful to get the doctors into ATP while they were suspended but Dr Waskett was told by the Deanery that this was impossible while they were not on the Performers List. NPSA had told him it would not be useful to have a case conference while they were suspended. Dr Waskett said he had forgotten

the comment by Dr Todd [1136] that the doctors should be booked into ATP in the expectation that they would fail and that he had in fact hoped they could be re-educated and pass. He agreed with the view expressed by the Deanery [1137] that ATP would not work at that time.

54. Dr Waskett accepted that he had made a couple of comments on Dr Cuthill's draft report where he thought the commentary did not reflect the facts. He said he presumed he had seen the recommendation that the doctors be removed but could not remember whether he had urged Dr Cuthill to delete it. He also could not remember the comment about the blood results [3197]. Dr Lock did not mention to him any misgivings about the LHB's support for the practice.

55. 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 urgency of referrals or attend to blood results although they may have needed training in communication skills.

56. 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.

Professor Richards

57. Professor Jonathan Richards said that the Practice Manager had been in post when he began his involvement with the doctors. He said that the Practice Manager exaggerated the progress made, for example the development of policies for repeat prescribing and thought that the Troedyrhiw surgery could be lived with whereas it was, in the opinions of himself and the GMC, acceptable.

58. 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].

59. 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 install 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.

60. 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 this had not had any effect.

61. Professor Richards accepted that Dr Cuthill found the standard of Dr Jha's referrals was adequate, although more detail would have been helpful [300]. He said that there had been no clear guidance for supervision and that he felt he could not guarantee safety, for example because he could not look at patients' records without their permission. He thought the training was evolving but had not been fully established.

62. Cross-examined by Mr Sutton, 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 and that the Practice Manager was not dependable and that it was not easy for the doctors to tell him to raise his game.

63. 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 showing them Good Medical Practice Guidelines ("GMP") and asking staff to think how they could help the doctors achieve the GMP standards.

64. 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.

Dr Lock

65. Dr Terry Lock gave evidence that he was he was not aware of any protocols when he first joined the practice in about 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], or that for house call [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.

66. Cross-examined by Mr Sutton, Dr Lock said that he had clarified that he was not acting as a workplace supervisor, as opposed to providing support to the Practice, in 2006 [997] and this was orally acknowledged by Dr Waskett.

67. Dr Lock agreed that he had completed the learning features on the form reporting the incident relating to Patient DL and said he had discussed it with Dr Jah possibly at the meeting on 2 May 2006 and that the latter had said he would undertake some research into the topic for a later meeting. Dr Jha said he was completing some CPD modules on prescribing for hypertension and showed him these on the practice computer.

68. On 25 July 2006 he met both doctors with Lesley Lewis and they discussed the cases of MG (angina), CP (rash) and DL and Lesley Lewis said she would write to the ATP mentor regarding learning needs identified by the meeting. Dr Lock said he had referred incidents to the LHB because he felt duty bound so to do and that other doctors and nurses in the practice felt the same. He did not feel he was acting under the instructions of the GMC.

69. He regarded the lack of equipment as the responsibility of the partners although he also said that requests had been made of the LHB. The condition of the surgical equipment was very poor, if not dangerous; he was frustrated with the bureaucratic processes of the LHB and shocked by the level of disinvestment in the practice and its services. He was under the impression that the doctors would sometimes log into the computer system not using their correct names.

Lesley Lewis

70. 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 encouraged to use them to tell the LHB about clinical incidents. She confirmed that the LHB had managed the practice from 1 April 2006

71. When she received a report [248] from the practice manager 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 [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.

72. Cross-examined by Mr Sutton Ms Lewis said that Dr Jha was not at the meeting on 2 May 2006 according to her recollection. She confirmed that the second page of the clinical incident form was only sometimes completed and was unable to confirm when she had first seen [243] or when [245-246] were first received. She agreed that the incident reported at [248] was generic in nature. She had written "Dr Prasad" in the top left hand corner because she was uncertain to which doctor it related and had had to ask the practice manager who told her he had discussed it with the doctors although she made no note of that conversation.

73. Ms Lewis said that it was not unusual for a nurse to bring the form to her by hand since she (Nurse Griffiths) was based at the LHB in an office next to hers. Other staff brought reports about other practices by the same means. Ms Lewis said she had not discussed this practice with Nurse Griffiths (although she may have known about meetings at the Practice) and did not influence the generation of the report.

74. Ms Lewis knew that arranging an ATP for Dr Jha was proving difficult. Her discussion with the doctors on 25 July was in the context of training needs but she also told them the LHB was receiving increasing numbers of clinical incidents on the same themes. She asked them how they were being pro-active about CPD since they had Thursday afternoons as protected time for this purpose. She agreed that the meeting on 25 July was constructive in relation to agreeing learning topics for a mentor but believed the LHB had to take into account patient safety.

Dr Jha's evidence

75. Dr Jha said that he agreed the conclusions of the GMC including the criticisms of his practice to which Professor Richards had contributed. He accepted that the appointment of the Practice Manager in April 2004 helped the position, also that close supervision and further training were necessary.

76. He produced a folder (File 7) containing his PDP materials. This included audits in 2005 of ACE inhibitor and NSAID prescriptions in view of the risk of renal failure, an audit of benzodiazepine prescriptions, a record of house calls, an audit of patients with hypothyroidism recommended by Professor Richards and two practice surveys. It also contained details of monthly CPD meetings, a lecture about difficult consultations and a certificate of completion of a course on myocardial infarctions.

77. Dr Jha had bought a book about communication skills in January 2006 and had asked the practice manager to contact Cardiff University about the course Professor Richards had recommended. This course did not start until May or June 2005 by which time he was concentrating on the GMC assessment.

78. Dr Jha produced a series of templates [3152-3158] that he said he had drafted then got his daughter to type and then sent to the GMC. He said he prepared these on his own initiative in March 2005 and included them in his PDP. He remembered doing role play about asthma with Professor Richards but nothing else [3187].

79. In December 2005 he went with Dr Prasad to see Dr Cruise, Dr Waskett and Maria Pryce to discuss the GMC assessment. They asked him to undergo Advanced Training and Dr Jha said he had written to the Deanery who had told him that he must be referred by the LHB for a placement. At that stage the LHB began talking about a change to salaried status. Dr Jha agreed Dr Waskett had said it would relieve him of management responsibilities. Maria Price said that the LHB would put Dr Lock, a salaried GP, into the practice to supervise him, as the GMC required. Dr Jha said he was focused on getting his training done and the conditions on his

practice lifted. In the event it was clear that Dr Lock did not feel he had a supervisory role. Dr Jha had no LHB induction when he became salaried. Dr Lock did not tell him he was sending incident reports to the LHB.

80. At the meeting with Lesley Lewis on 2 May Patient DP was mentioned and at that of 25 July Patients DL, CP and MG were discussed. Dr Jha said he was still committed to AT and to taking the assessment thereafter. He wanted to return to the practice where he had been since 1994 where he liked and was liked by his patients.

81. Dr Cuthill had never contacted him. Dr Jha would have liked to have been able to give his side of the story; for example he could have told him it was Dr Jones, the locum, and not he who had sent patient DL for the ECG.

82. Dr Jha was taken through Dr Cuthill's report. He said he had tried to persuade patient DP to go to hospital: he was breathless with breath reduced at both bases with swollen ankles and difficulty speaking. Dr Jha felt the patient may have had a cardiovascular problem with a chest infection superimposed on it. He thought it would take time to organise an ECG in the Aberfan surgery and wanted the patient to go to hospital. A blood test a month earlier had revealed an overactive thyroid that might have caused a fast, irregular heart rate. Dr Jha wanted a consultant to see him to get all necessary tests done and have a definite assessment. He gave him a water tablet and an antibiotic; it did not occur to him to ask him to come back in 48-72 hours. He had seen the patient for 12 years and had the patient's trust; he tried but failed to influence the patient telling him that his blood was abnormal, that he might have a heart problem but that he could not tell without investigations. Dr Jha accepted that his recording skills could be improved.

83. Dr Jha confirmed that he had not carried out the ECG on patient DL, had left the care of the patient to Dr Lock and had not begun the patient on Digoxin or Soletol. He defended the legibility of his note on [1853].

84. Dr Jha said that it was Dr Prasad who had prescribed Enalapril for Patient MG for hypertension and that the patient had been put on the hypertension register because she was on a hypotensive drug. He did not question his colleague's judgement or reassess the patient. He thought the patient's pain could have been muscular in origin so he tried her on isosorbate mononitrate and told her to come back in two weeks, warning her of the risk of headaches. She was not happy and went to Dr Lock.

85. Dr Jha agreed it was a serious mistake not to record the consultation on 20 June 2006 and said he could not remember why he had not – it might have been that he was running out of time or that there were patients waiting but it was in any event an error. He had not spoken about it with Dr Lock because there was a big communication gap after the Practice Manager told him Dr Lock was sending incident reports to the LHB. This aggrieved Dr Jha and affected his communication with others.

86. Dr Jha said that he had used a calculator of the risks of cardiovascular disease for the patient, taking into account that she was a smoker who had already had lifestyle advice and had LDL of 3.9 and cholesterol of 6.33. He pointed out that prescriptions of both drugs continued after his suspension.

87. Dr Jha admitted that his diagnosis of patient CP's tinea vesicolor was wrong but denied telling her that it would never clear up. He had treated this incident as a learning issue.

88. In general he maintained that he had always actioned blood results and repeated blood tests only when necessary.

89. In relation to Patient TE-R the LHB only pursued the criticism of provision of inadequate treatment. Dr Jha knew this patient from giving him Zoladex injections. When asked to visit the

patient he looked at the records on the computer and read the letter from the hospital before ringing the patient's daughter to ask about his pain, whether he was conscious, ambulatory and how his breathing was. He told her the pain was from the cancer spreading into the bone and that he would fax a prescription for a painkiller to Boots for collection. She agreed. Dr Jha said that he then said he would visit on his way home but that he had not in fact visited. He did not appreciate how acute the situation was; if he had felt the urgency, he would have gone. He then said he could have visited, if the daughter had given him a second request and then that he had said that he would visit, if she rang him back to ask.

90. Dr Jha felt he had eliminated spinal cord compression by asking whether the patient was walking and emptying his bladder. He thought two co-codamol 500mg every six hours was adequate pain control in palliative care. In hindsight he accepted that he should have visited, that the prescription was insufficient and that he should have arranged palliative care.

91. The LHB was not alleging fraud in relation to the blood pressure reading of 131/79 for patient AL; Dr Jha accepted that he might have made an error in performing or recording the test.

92. He did not accept Dr Cuthill's criticism that he failed to examine women patients; he used a chaperone and obtained consent. He did accept that he needed to make fuller records. He always did his best to action laboratory results although he was not foolproof. In relation to medication reviews he improved, following Professor Richards' advice, but needed to put more in the records. Dr Jha described the process of the review including the consultation and the need to be flexible. Until 2002/2003 he might conduct the review in the absence of the patient but stopped this after training at the Pontcae Surgery and Professor Richards' advice.

93. Before 1 April 2006 the practice had protocols for CHD, diabetes, asthma, hypertension and cervical smears which they disclosed for the new GMS contract. He saw a list of housebound patients shown to him by the Practice Manager but could not remember whether the dates of birth were listed. All clinics for chronic disease management were led by a specialist nurse. Those patients were seen six-monthly by a doctor or more frequently, if necessary.

94. 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.

95. Dr Jha told Ms Morris in cross-examination that the receptionists did not know what to do. In relation to Patient MG he admitted that he made no record of seeing her on 20 June 2006. He said he recalled the consultation but did not know whether it was am or pm; he had a slight recollection after looking again at the records. He knew the family history because he used to treat the patient's mother at her home and thought that the mother's angina was an important factor in his diagnosis for this patient. He accepted that a locum would not have known of the family history from the records. It was put to him that he knew the importance of record-keeping from Professor Richards and asked what stopped him making a record in this case. Dr Jha was unable to explain but said that he will keep it in mind all the time and that training would help him know what and how to record.

96. He said that the prescription of ISMO was on a trial basis so that there was no examination or referral. He did not refer her until he had seen that it was not a typical chest pain on effort or with radiation; he would not prescribe ISMO without referral again; he would do an ECG and refer, even if he suspected angina, to a cardiology consultant for an exercise test. Dr Jha was unable to explain when the diagnosis of hypertension to justify the prescription of Enalapril was made and suggested it might have been at a Well Woman clinic. He denied making the diagnosis and prescribing Enalapril.

97. Dr Jha accepted that there was no note of a low TSH level at the consultation with DP on 13 February 2006 and that the record was incomplete. He said that he knew the level had been taken into account because he would bring together all aspects of the case to persuade the patient to go to hospital. He accepted the patient should have been told to come back in 48-72 hours: an ECG could not have been done at the Aberfan surgery because the nurses were not there in the afternoon.

98. Dr Jha accepted that it was improbable that Patient AL's blood pressure was 131/79 on 10 July 2006 but did not think he had made an operating error because the instrument was electronic. He accepted he might have read or entered the result incorrectly and that the mistake exposed the patient to risk.

99. He said that he and Dr Prasad and the clinical and practice staff and the practice manager were responsible for the protocols. Clinical audits were done to improve the standards of care and allow evaluation of outcomes against targets and implementation of changes. He acknowledged Professor Richards' advice [3168] that audits should be done regularly.

100. Dr Jha said that he had redone the ACE inhibitor audit [2786] then accepted that he had not although he knew it needed repeating. Nor had he redone the audits for NSAIDs [2825] or levothyroxine [2908] although it was anticipated on the face of the audit documents that they would be repeated.

101. Dr Jha said that he could not now go to CPD meetings but that he had been reading. He went to India because he felt very low and needed either psychiatric help or a change of scenery. He had had domestic problems to sort out and was feeling much better now. He had not taken any courses but felt that the LHB should have paid for him to go on a course to remedy his weakness in dermatology. Clinical supervision would explain how to perform better and give some reference how to repair clinical deficiencies. He accepted it was always open to him to seek help and that he needed someone to rely on, if in difficulties. He did not think he had slipped back after Professor Richards withdrew.

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 (the LHB) and 22 February respectively.

Submissions by the LHB

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 Jha 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 Jha'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 Jha 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 Jha 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 Jha 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 both what was expected of doctors and that Dr Jha knew or ought to have known what was expected of him. That guidance, Good Medical Practice for GPs, 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 your 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 your 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 MG on 20 June 2006 and with TE-R on 13, 19 and 23 June 2006;
(b) failed to action abnormal test results and giving inappropriate reassurance: DP January 2006;
(c) failure appropriately to examine and treat and delay in referring: DP 13 February 2006; MG 20 June 2006 – prescription rather than investigation or referral, no record to support exercise of clinical judgement;
(d) failure to undertake intimate examinations when indicated;
(e) incorrect diagnosis of hypertension: MG January 2003;
(f) inaccurate taking or recording of blood pressure: AL 10 July 2006;
(g) inadequate arrangements for housebound an terminally ill patients: TE-R June 2006;
(h) unsatisfactory CPD and PDP, protocols and clinical audits;
(i) 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 Jha's knowledge supplemented by a year's assistance from Professor Richards.

108. Contingent removal was inappropriate because:

a. the failings were so basic that they indicate a fundamental "inefficiency" which is unlikely to be capable of remedy e.g. to make notes of consultations, to put key facts in referral letters, and to examine patients, and conditions cannot therefore manage the risk;
b. the nature of the failings and the risks they raise were 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 Jha is criticised in these proceedings (as well as a history of previous input); Dr Jha did change to some extent with the presence of Professor Richards but these changes were not sustained after he ceased to be involved and this leads to the inference that Dr Jha is incapable of the change necessary to allow him, after further training and supervision, to return safely to independent practice since it cannot sensibly be suggested that it is conducive to the efficient provision of medical services that he should practice with supervision for ever and provide medical services efficiently;
e. Drs Jha's errors and/or failings were in areas of practice for which he was personally responsible as a professional, whether a salaried GP or not, and whether subject to advanced training or supervision or not;
f. Dr Jha 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;
g. the prejudice to the public interest in this case outweighs any potential submission that individual doctors of the characteristics of Dr Jha as set out above should be given yet another chance.

109. It was submitted that: (a) the failure to visit patient T E-R indicated a fundamental lack of care for patients which is not likely to be changed by training or supervision; (b) while Dr Jha was able to produce documents to suggest that he had reflected upon his training needs, he was significantly unable to demonstrate that he had responded to the training provided by Professor Richards e.g. in respect of clinical audit; (c) while he remains suspended or subject to another additional sanction from the GMC he cannot return to practice in order to undergo the proposed supervision or training: it would not be an efficient or appropriate use of resources for him to remain on the Performers List in these circumstances.

<u>Submissions on behalf of Dr Jha</u>

110. The primary submission was that the justified criticisms of his practice are fully capable of being addressed through AT and a period of supervised practice: his practice was considered remediable by the GMC and, indeed, by the LHB itself in July 2006.

111. Dr Jha responded in relation to specific criticisms as follows. Patient DP: the patient refused to accept his advice to go to hospital for further investigation; the issues of no specific record whether the blood test was taken "fasting" and of borderline diabetes were not matters relied on

by Dr Lock or the Reference Panel; the LHB's submission that Dr Jha failed to arrange an appointment once the blood test had been actioned was a new complaint to compensate for Dr Cuthill's incorrect allegation that a blood test had not been actioned.

112. Patient DL: the failure to refer the patient for a cardiology opinion was wrongly attributed by Dr Cuthill to Dr Jha rather than Dr Jones and his criticism that Dr Jha had not actioned the abnormal blood result was also wrong; the record written by Dr Jha was legible.

113. Patient MG: Dr Jha accepted that his entries in the records were inadequate; the prescriptions of Enalapril were made by Drs Prasad and Jones; he chose to prescribe Simvavastin and ISMO in the light of his knowledge of the patient.

114. Patient CP: Dr Cuthill's true opinion was that this was not a significant event [3196] and his decision to include it in his report was incompatible with his acknowledged duty to highlight exonerating as much as incriminating material.

115. Clinical Incidents 4 and 6: Dr Jha drew our attention to the fact that these were generalised criticisms unsupported by records and derived in part from the Practice Manager whose qualities were roundly criticised by Professor Richards.

116. Patient CM's complaint: withdrawn and complaint was made that attempts by the LHB to introduce it in the appeal were wholly unacceptable and oppressive.

117. Patient TE-R: Dr Cuthill had quite wrongly alleged a failure to refer the patient. Dr Jha disputes the assertion by the patient's daughter three months after the event that he had refused to make a home visit and asks us to prefer the version in his witness statement in which he said that he would certainly have visited the patient at home, if his pain had worsened notwithstanding the pain killers he had been prescribed. He asks us to apply a high standard of proof owing to the seriousness of the allegation and refers to the absence of evidence from the patient's daughter.

118. Patient AL: the LHB had again acted oppressively by advancing a case of falsification of a blood pressure reading without notice; Dr Cuthill had wrongly alleged that the patient had not had a blood pressure reading since the birth of her son (whereas it was clear from the records that she had). The LHB had the in the course of the hearing changed to an allegation of incompetent taking or recording of the test: Dr Jha gave evidence that the device produced a digital reading and that he believed he had recorded it accurately.

119. Dr Jha asked us to treat Dr Cuthill's generalised allegations with caution, complaining of his failure to interview Dr Jha and drawing attention to the deficiencies of the Practice Manager, to the LHB's lack of support to the Practice (undisclosed in his report) and to Dr Lock's apparent lack of criticism of the way in which pathology reports were actioned. In addition Dr Jha submitted that he had been criticised unfairly in relation to his CPD in respect of which he found himself in a vacuum after his suspension despite which he made arduous attempts to keep himself up to date on his own initiative. He referred to the response to the GMC assessment that he had drafted in relation to his learning needs [3150].

120. It was submitted that Dr Jha's practice was remediable (as the GMC assessment concluded) and that he was "conscientious, caring and motivated" and clinically able (according to Professor Richards). The LHB failed to provide workplace supervision and the advanced training offered as an incentive to become salaried was never provided; the LHB saw the acknowledged failings of Dr Jha as susceptible to training.

121. Dr Jha submitted that the "logistical difficulty" in finding an ATP should have been overcome in order to repay his 15 years service in an isolated and demanding setting and that, if Dr Lock

had been acting as a workplace supervisor, the suspension may never have been made; unsupported as he was, however, he was subject to increased scrutiny.

122. We were urged to ignore the potential impact of the future proceedings before the GMC in concluding whether to make a contingent removal.

123. In a final section of the submissions trenchant criticism was made of the procedural unfairness of the LHB proceedings: the investigation, and in particular Dr Cuthill in the compilation of his report, had failed to refer to exculpatory evidence or to interview Dr Jha contrary to his hitherto unfailing practice. At the LHB hearing Dr Cuthill said that the latter was because of Dr Jha's absence in India but on this appeal he said it was because the ToR did not specifically require it. We were asked to regard this latter explanation as implausible because Dr Cuthill did in fact interview witnesses when not required by the ToR so to do. Had he done so, a number of his criticisms would have been abandoned or modified.

124. The disclosure process was also criticised as late. Where it had occurred complaints had been abandoned. Dr Cuthill's draft report had included a recommendation for deletion of Dr Jha's name from the List and it was apparent that Dr Waskett had contributed to Dr Cuthill's apparently independent report. Criticisms were made of the procedure before the Reference Panel and of the involvement of Dr Lock's membership of it. We were asked, in the light of these criticisms, to find that at least as far as the investigation and Reference Panel stages are concerned, the proceedings have not been conducted in accordance with the minimal standards of fairness.

Discussion

Procedural unfairness

125. It seems logical to us first to consider the procedural unfairness point first. Dr Jha concedes that a re-determination is capable of curing some of the ills in the LHB process. What is not said, however, is what we should conclude is the legal consequence for our decision of unfairness in the LHB proceedings: it is noteworthy that there is no allegation of procedural unfairness in the appeal before us. Mr Sutton cites well-known authorities in relation to the presence of Dr Todd on the Reference Panel but no authority on the effect of any such unfairness on our re-determinative proceedings. It was put to Mr Sutton in the course of hearing that these matters should go to the weight to be given to the evidence led on behalf of the LHB: we see no argument to the contrary in Dr Jha's submissions.

126. Those submissions invite us (at 5.1) to make specific determinations "as to certain features of the respondent's conduct of the investigation and hearing below which have caused particular concern to Dr Jha and his advisers and which have served to impugn the fairness of the process viewed as a whole". As a step precedent to our findings on substantive matters we do this now, arguably out of the order in which this decision is structured.

127. We find: (a) Dr Cuthill's decision not to interview Dr Jha (or, indeed, Dr Prasad) was contrary to his usual practice, unsatisfactory and not adequately explained either by Dr Jha's absence in India or by the ToR; (b) this failure led to criticisms being included in his report that would otherwise have been omitted or modified; (c) the disclosure given by the LHB may have caused difficulties at the Reference Panel stage but did not give rise to any procedural unfairness before us; (d) the recommendation in Dr Cuthill's draft report was wholly inappropriate for an independent investigator but his explanation why he removed it is uncontroverted and consistent with good practice; (e) there is no doubt that Dr Waskett intervened (as he should not have been allowed so to do) in the reporting process: it is impossible to determine to what extent; (f) we accept that the position of Dr Lock was ambiguous and highly unsatisfactory; (g) we do not propose to make detailed findings in relation to the conduct of the Reference Panel since there is no suggestion that any party did not have a fair hearing before us: this seems to us to be the quintessential purpose of our re-determination of the allegations. Further, we do not have a transcript of the Reference Panel in any event.

128. Accordingly we consider that our task is to weigh the evidence on the allegations that survive in the light of the strictures referred to in the last paragraph and of the impressions we had of the witnesses as they gave evidence before us.

Criticisms of Dr Jha's practice

129. As to specific patients there were the following criticisms: Patient MG: record-keeping; examine/treat/referral; diagnosis; Patient DP: actioning results, examine/treat/referral; Patient TE-R: record-keeping; failure to make a home visit; Patient AL: failure accurately to perform or record a blood pressure test.

130. More general criticisms were made in relation to Dr Jha's CPD and PDP; the protocols available in the Practice; failure to conduct clinical audits and in general failure to rectify shortcomings between January 2003 and July 2006 despite help from the LHB. In relation to these criticisms the contentions of the parties and the underlying evidence are amply set out above.

Findings

131. Patient DP: Dr Jha accepted that this patient needed further investigation but maintained that the patient refused to accept his advice. The advice given was not documented and the patient should have been reviewed within 48-72 hours as Dr Jha accepted.

132. Patient DL: the criticisms in this case were unfounded and arose at least in part from Dr Cuthill failing to interview Dr Jha.

133. Patient MG: Dr Jha accepts that his notes were inadequate but defends his prescription of Enalapril and ISMO. We find that Dr Jha should have urgently referred the patient for a cardiological assessment.

134. Patient CP: it appears the LHB does not maintain its criticism in this case. It is equally clear from Dr Cuthill's report that he considered the problem to be minor: this seems to us to blunt the criticism by Dr Jha that Dr Cuthill did not deal fairly with exonerating features of the evidence.

135. Patient CM: this criticism was withdrawn. It will be clear from our previous rulings that we did not find the matter as clear cut as is suggested on Dr Jha's behalf.

136. Patient TE-R: we accept that Dr Jha failed to visit the patient at home and consider that this was very poor care indeed. The submission that he would have visited, if the patient's pain had worsened, sits very uncomfortably with the three different versions of the story that Dr Jha offered in evidence.

137. Patient AL: what is not in doubt is that the blood pressure reading of 131/79 on 10 July 2006 is clinically implausible. Dr Jha appeared to accept in his evidence that something may have gone wrong with the test or the equipment. We find that this is the most likely explanation for the result. The subsequently very much higher readings should have prompted Dr Jha to investigate the patient further.

138. In relation to housebound patients we have not seen a register: Dr Cuthill's report deals explicitly with its absence. We accept that Dr Jha's Personal Development Plan was quite inadequate and find that his 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 and thereafter, if integrated into the practice, genuine improvement in the quality of services delivered.

139. 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 the partners as a

Trojan Horse from the LHB more interested in finding fault than helping improve a difficult practice. But all this must be seen from the perspective that Dr Jha 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.

140. Problems with Dr Jha's practice emerged in 2003 and worsened in 2004. Supervised practice seemed to have helped but a GMC assessment found him wanting. Dr Jha 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 Jha had alleged that the LHB had cancelled his brief to help him. We have no hesitation in accepting Professor Richards' evidence that he gave up in despair of getting Dr Jha to change his professional habits.

141. Dr Jha was neither provided the supervision envisaged by the condition imposed by the GMC nor started 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 Jha's practice independently sound.

142. The question for us is whether Dr Jha's presently unsound practice is remediable? We heard him give evidence and our impression of him was that his professed keenness to learn had not been reflected in his performance since the intervention of the GMC in 2004. We share Professor Richards' uncertainty why a doctor with possible sanctions hanging over him would not take steps to resolve his difficulties pro-actively. In the event Dr Jha seemed to have expected the LHB to take all steps on his behalf, particularly after his change to salaried practice in April 2006.

143. We could not understand his evidence that the audit of ACE inhibitor prescriptions had been repeated when it was perfectly clear from the materials he had himself produced for the hearing that it had not been. In addition, we were highly unimpressed by the manner in which he shifted his ground when attempting to justify his failure to make a home visit to Patient TE-R.

144. Although some of the LHB's criticisms turned out to be ill-founded, those that we have accepted show evidence of fundamental failures in record-keeping, referrals and the standard of care provided to his patients. We are impressed by the fact that improvements made by Dr Jha after the period of supervised practice at Pontcae and the mentoring provided by Professor Richards were not sustained.

144. We accept that Dr Jha was removed from the List before the AT and workplace supervision required by the GMC had taken place and that the specific allegations that we have accepted are not of the most serious; on the other hand we are struck by Professor Richards' description of Dr Jha's failures to sustain change that led him to despair of helping him.

145. The shortcomings we have identified may well be remediable and, on a fine balance, we conclude that Dr Jha should be given what must be a final chance to bring his practice up to GMP standards. The conditions attached to a contingent removal must be stringent.

Decision and Order

146. For the reasons set out above we are of the view that the appeal should be allowed and we order that Dr Jha should be contingently removed from the LHB's Medical Performers List subject to the following conditions:

(a) Dr Jha to confine his performance of primary medical services (whether directly employed by the LHB or not) to general practice posts of a duration of not less than one month and within a partnership or group practice approved by the LHB of at least three partners or members, one of whom will act as his named supervisor;

(b) Dr Jha to seek a report from the named GP supervisor to the LHB on a three-monthly basis from the start of Dr Jha's employment or engagement setting out an assessment of Dr Jha's practice;

(c) Within four weeks of this decision Dr Jha to refer himself to the Cardiff Postgraduate Deanery ("the Deanery") for an assessment of his learning needs;
(d) Dr Jha to co-operate with the Deanery in undergoing supervised training as recommended as part of a learning development plan drawn up by the Deanery, such training to last not less than six months;
(e) Dr Jha to participate in and pass a final assessment to be approved by the LHB in conjunction with the Deanery within a year of this decision and, for the avoidance of doubt, condition (a) above shall remain in force until this condition shall have been satisfied. If he fails to pass the assessment, the LHB will be at liberty to restore the matter to us;
(f) Dr Jha undertakes to provide himself or permit disclosure to the LHB of:
(i) all documentation in relation to proceedings before the General Medical Council and to comply fully with any conditions that may be imposed upon his registration by the General Medical Council and
(ii) all assessments and reports prepared by or at the request of the Deanery and/or any other body or person from whom any reports are requested by the GMC;
(g) Dr Jha to allow the LHB to exchange information with any organisation for which he provides medical services;
(h) Dr Jha to contribute half the cost of the training, assessments and examinations referred to above up to a maximum contribution by him of £15,000;
(i) Doctor Jha will within 28 days of a written request from the LHB confirm in writing his acceptance of these conditions in their entirety.

147. The confirmation referred to in paragraph 146(i) must necessarily be subject to the current suspension by the GMC. The LHB is, however, entitled to know where it stands. If Dr Jha accepts these conditions within 28 days, they will come into force if and when he is allowed by the GMC to return to practice and subject to any further conditions it may impose on his practice and these conditions should be read accordingly. If he does not accept them, he will be removed from the List. We have imposed these conditions without hearing submissions (except that the removal should be outright) from the LHB. If it has concerns about the practicability of them, it should seek a review – see paragraph 149 below.

148. 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.

149. 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.

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Mark Mildred
Chair of Appeal Panel
6 March 2008