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In the Family Health Services Appeal Authority case no: 14742

Heard at Harrogate	
On 23-26 February 2009	

Before
Mr J D Atkinson (Chairman)
Mr A Woodcock
Mrs C Greene

Between

Ms Pamela Brompton

Appellant

and

North Yorkshire and York Primary Care Trust

Respondent

Representation:

For the Appellant: Mr Reissner, Charles Russell, Solicitors
For the Respondent: Mr McCartney of Counsel

DECISION AND REASONS

The Appeal

1. This is an appeal by Ms Brompton against the decision of the respondent dated 29 August 2008 that the appellant be subject to contingent removal from the respondent's pharmaceutical list.

The Proceedings

2. On 4 August 2008 the respondent, following a PCT panel hearing, decided to contingently remove the appellant from its pharmaceutical list on the grounds of efficiency.

3. The terms of the condition imposed were as follow

The appellant is to be removed for the pharmaceutical list unless the appellant agrees to be examined by an independent consultant occupational health physician and that, should such assessment identify any health concerns, that the PCT receives

assurance that these concerns can and are being addressed

4. In summary terms, the grounds for making that decision were that over a number of years and on a number of occasions the appellant had behaved in ways that were of concern and had a prejudicial impact on the efficiency of services.

5. On 15 August 2008 the appellant appealed to the FHSAA against that decision. Appeals to the FHSAA are by way of redetermination

The Law

6. The relevant legal framework is set out in a combination of primary and secondary legislation. It is not disputed that the substantive requirements for contingent removal may be summarised as follows.

7. The respondent may remove a practitioner from the pharmaceutical list where the continued inclusion of the practitioner in the list would be prejudicial to the efficiency of the services which those in the list undertake to provide (an efficiency case).

8. In considering removal from its list the following summary of matters, inter alia, shall be taken into account

> The nature of any offence, investigation or incident
>
> The length of time since any incident
>
> Any action taken by a licensing, regulatory body or the police
>
> The nature of any incident and whether any such incident posed a likely risk to users of pharmaceutical services
>
> Whether the practitioner has been removed, contingently removed or is currently suspended from any list on fitness to practice grounds

9. In an efficiency case, the respondent may instead of deciding to remove a practitioner from its list , decide to remove her contingently. If it so decides it must impose such conditions as it may decide on her inclusion in the list with a view to

> (a) removing any prejudice to the efficiency of the services in question….

The documents and evidence considered

10. For the hearing, the respondent filed a bundle indexed and paginated to 246 with appendices ending at D2/93. The respondent also relied on the oral evidence of a number of witnesses, a summary of which is set out below.

11. For the hearing the appellant filed three bundles, indexed and paginated to 354, 320 and 301 respectively. The first bundle however was largely superseded by the second bundle. The appellant elected not to give or adduce oral evidence.

12. In the course of the hearing leave was granted for the filing of the following further documents: Poppleton Pharmacy Record of events 1 April 2005 to 31 August 2005 (paginated to ZZ) and an extract from Pharmacy Law and Practice on Professional Standards.

Preliminary matters

13. At the outset of the hearing Mr Reissner on behalf of the appellant applied for leave to make a tape recording of the proceedings. Mr McCartney raised no objection in principle but expressed concerns about the form and nature of the recording equipment. The Panel refused the application because no provision is available within the FHSAA jurisdiction for a proper transcript of the proceedings to be made and the parties were unable to identify any issue that meant the recording was necessary in the interests of justice.

14. Mr McCartney also drew the Panel's attention to the question of whether and in what circumstances it would be appropriate for the Panel to draw an adverse inference from a failure of witness to give oral evidence and asked for guidance from the Panel. Mr Reissner submitted that it was not helpful to consider such evidential matters in terms of the drawing of adverse inferences which was a term more appropriate to criminal proceedings.

15. It is not necessary to set out the full extent of the competing submissions here, however having retired to consider the matter the Panel indicated that its approach in principle was as follows.

16. In determining the appeal the Panel considered that the burden of proof lay with the respondent and that the appellant was entitled not give oral evidence. The Panel would come to its determination on the basis of the evidence adduced, and where it was fair and proper to do so was entitled to treat the failure of a party to give oral evidence as a matter that could provide additional support for the case against them.

Opening submissions on behalf of the Respondent

17. Mr McCartney relied on his opening statement and made further submissions that may be summarised as follows. The respondent's case was that the appellant should be contingently removed and subject to a condition to undertake an occupational health assessment. There was no dispute that the substantive criteria for contingent removal was as set out in terms summarized above.

18. There was a dispute about the ambit of the phrase *where the continued inclusion of the practitioner in the list would be prejudicial to the efficiency of the services which those in the list undertake to provide*. The respondent's position was that the efficiency aspect of the criteria should be widely construed given that the wording referred *to the services which those in the list undertake to provide* as opposed to 'the services of the individual practitioner'. Further support for that proposition was to be found by the definition of *essential services* as set out at in schedule I part 2 -3 where it is indicated that for the purposes of the pharmaceutical regulations essential services means

    a- the services described in the relevant part and

    b- the activities described in this part to be carried out in conjunction with those services

19. The respondent's case is that it is the appellant's conduct and the manner of her reaction to events that would be prejudicial to the efficiency of services in this case. The respondent take the view that it is the cumulative effect of the incidents, and not the appellant's clinical ability that gives rise to inefficiency, although the appellant's behaviour may have an effect on clinical issues. More specifically the inefficiency arises from the time wasted in dealing with the appellant and from the manner in which she herself deals with issues.

20. The respondent's approach to the issues is to seek an independent occupation health assessment with a view to supporting the appellant. The respondent has not approached the

matter on the grounds of it being an unsuitability case, because such an approach would not allow for contingent removal.

21. The inefficiency in this case therefore arises under the following broad heads : (a) the actual time wasted in dealing with appellant; (b) issues of clinical safety ; (c) the undermining of public trust.

22. The respondent's view is that the clinical concerns about patient safety are justified and the medical evidence from Drs C and G show that there might be health concerns that should be addressed by an occupational health assessment.

Oral Evidence on behalf of the Respondent

Mr S Mason
Legal Services Manager

23. Mr Mason adopted his statement of 10 August 2007 together with the transcript of his evidence given at the respondent's panel hearing, as evidence in chief. Extracts of his further oral evidence may be summarized as follows.

24. Mr Mason was aware that there had been a previous complaint about the dispensing of paracetamol from the appellant's pharmacy and that he had written to the appellant indicating that no further action would be taken. The respondent had made reference to such a matter in the context of judicial review proceedings and it was understood that Dr Geddes in his statement makes reference to such a matter. Following the judicial review proceedings the respondent reconvened a meeting at which no reference was made to the issue. It is accepted that the issues relating to the paracetamol incident did not form the basis of any disciplinary proceedings.

25. Mr Mason accepted that he was not aware of what the appellant had said to Sergeant Ogden in the context of the appellant approaching the police with her concerns about the conduct of the respondent and Mr Mason personally. Mr Mason had been telephoned by Sgt Ogden, but had not made a contemporaneous note of what was said. It was accepted that there was nothing wrong in the appellant contacting the police if she thought that she was being harassed. Mr Mason had advised the appellant that if she thought an offence had been committed then she should approach the police.

26. The note at page 196 of the respondent's bundle relates to a telephone conversation with the appellant on 11 October 2006. Mr Mason did not recall mentioning an occupational health assessment at that time: the focus was on undertaking a pharmacy assessment. Nor did Mr Mason recall any suggestion that the appellant was awaiting a response from the respondent on a number of points following the meeting on 9 February 2006 or any other matters not set out within the note.

27. The appellant had been subject to anonymous complaint about the closure of the pharmacy at a particular time but those issues related to a period before his employment with the respondent. The receipt of the complaint was a matter that was considered by the reference panel.

28. The appellant requested in March 2008 an assurance from the respondent that the incident relating to the sale of paracetamol was not a matter that would be considered further. Mr Mason took the view that it was unreasonable for the appellant to raise this matter with the respondent because the complaint about the paracetamol had been investigated and it was shown that the appellant was not on duty at the time. As far as the respondent was concerned, that was the end of the matter subject to one rider. Mr Mason had interviewed the

complainant whose main concern was the manner of her treatment when bringing the complaint to the attention of the appellant.

Ms S King
Primary Care Manager,
North Yorkshire and York Primary Care Trust

29. Ms King adopted his statement of 10 July 2007 together with the transcript of her evidence given at the respondent's panel hearing, as evidence in chief. Ms King 's managerial responsibilities included managing the department relating to pharmacists and pharmaceutical services. Extracts of her further oral evidence may be summarized as follows.

30. Ms King has had scores of telephone conversations with the appellant since 1993 averaging about once per month. This is a high level of contact. On average about half the telephone calls with the appellant involved occasions when she was aggressive, shouted and was irrational in her approach to Ms King.

31. In relation to an incident concerning the disposal of clinical waste in February 2002, Ms King received a telephone call from the appellant. She clearly overheard the appellant talking to the employee of the waste disposal company in a loud and aggressive manner.

32. It was accepted that it was reasonable for the appellant to contact the PCT about pharmacy matters and if correspondence did not give her correct title. A telephone once per month on pharmacy matters would not be unreasonable.

33. On the issue of disposal of clinical waste in 2002, Ms King was not aware at the time that the appellant was concerned that the waste was being removed inappropriately in plastic bags. Ms King understood that other pharmacies had problems with disposal of waste.

34. Ms King was aware that an issue arose over the pharmacy rota for the Christmas period in 2005. Correspondence to the appellant had been delayed because it needed to be seen by the Chief executive before being sent. The chief executive was used as a filter because the appellant sent conflicting information on a number of matters.

35. The respondent rarely had contacted with other pharmacists unless there was specific issue. The respondent had received considerably more telephone calls from the appellant than from any other pharmacists.

Dr Clarke,
Director of Public Health,
Craven Harrogate and Rural District Locality

36. Dr Clarke adopted his statement of February 2007 together with the transcript of his evidence given at the respondent's panel hearing , as evidence in chief. Dr Clarke became involved with the appellant at the direction of the acting chief executive of another PCT, Selby and York PCT, to investigate the outstanding concerns of both parties following the Strategic Health Authority report in November 2005. Extracts of his further oral evidence may be summarized as follows.

37. Dr Clarke first met the appellant on 13 December 2005 at the request of the chief executive. The meeting was attended by a number of PCT officers and the appellant and her supporter Mr Macdonald. Dr Clarke had not read any of the papers relating to the issues concerning the parties. He wished to bring a fresh pair of eyes to the matters in issue between the appellant and the North Yorkshire PCT, of which he was not an officer. He wished to give the appellant an opportunity to 'offload' her concerns; however within a short period the appellant stood up and said that she had had enough and left the meeting.

38. The meeting continued with her supporter Mr Macdonald. The appellant returned to the meeting after about an hour. Dr Clarke agreed that he would write to Selby and York PCT in order to obtain a list from them of their concerns. That list was obtained in preparation for the second meeting of 9 February 2006.

39. On 9 February 2006 the parties met. Selby and York PCT had provided a list of concerns. In themselves they did not amount to a disciplinary matters but taking account of their number, the length of time over which they occurred, their volume and the nature of the appellant's response, Dr Clarke had formed the view that an occupational health assessment would be of assistance in assessing any risk to public safety. Such an assessment would amount to advice to the respondent giving assurance as to patient safety. It would also be a source of support and advice to the appellant. In addition, as part of a twin track approach it was planned that a pharmacy assessment under the new regulations was to be undertaken.

40. Dr Clarke introduced the meeting on 9 February 2006, explained that he had received the list of concerns from Selby and York and went on to consider how the issues might be resolved by pharmacy assessment and an occupational health assessment. After about 10 minutes the appellant stood up, positioned herself behind Dr Clarke and held a cup of hot water over his head. The other members of the meeting told the appellant not to pour it over Dr Clarke. The appellant put the cup down and left the meeting. This incident confirmed Dr Clarke's view that the appellant had a volatile nature and engaged in extreme behaviour.

41. Dr Clarke's main concern was patient safety. Selby and York PCT had expressed concerns about the strains on relationships between professionals and the incident on 9 February 2006 was an added concern.

42. An occupational assessment would also assist the PCT given that it had already put in place special measures to for dealing with contact with the appellant and given the anxiety of the staff in taking calls from the appellant. Rachel Ainger was designated to take calls from the appellant on pharmacy matters, otherwise calls were directed to Elizabeth Walker primary care manager, Dr Clarke himself or the legal services manager. The need for such arrangements had an effect on the efficiency of services where staff need to deal with important, complex matters and the demands of other pharmacists. There was an opportunity cost involved in making such arrangements.

43. Dr Clarke accepted that it was reasonable for the appellant to raise a legitimate inquiry on matters falling within the responsibility of the PCT, however, how such an inquiry was made was a concern in terms of the nature and length of the call.

44. Dr Clarke's involvement was to provide a clinical perspective on risk to patients, not to give a clinical diagnosis of the appellant. His role was to look at both the appellant's concerns and the PCT's concerns. For the first meeting on 13 December 2005, Dr Clarke had not read the papers because he wished to come with a fresh pair of eyes and not carry any baggage. Dr Clarke had opened the meeting by saying that he needed to understand matters from the appellant's perspective and that the second stage would be to look at the PCT's concerns and the Strategic health authority report. The appellant had a different agenda but before that was reached the meeting broke up and there had not been a proper debate.

45. At the end of the meeting in December Dr Clarke agreed to obtain a list of concerns from Selby and York PCT. He was also handed a bundle of material [note – this was subsequently admitted in evidence but not put to the witness]. No formal reply was given to the material because the nub of the matter was that he and the appellant had not been able to enter into a dialogue at either the December or February meetings. The objective of the meetings was to arrive at a working arrangement between the PCT and the appellant. This approach had been discussed with the chief executive. It was important to appreciate that

there were two perspectives, the appellant's and the PCT's. Dr Clarke's role was not to investigate the relationship but to look at how to re-establish a working relationship and not pass judgment.

46. Dr Clarke first raised the issue of an occupational health assessment at the second meeting of 9 February 2006. He had not written to the appellant before then because to put such a matter in writing would have been cold; experience showed it was better dealt with in discussions. This was not to take a one sided approach. The assessment would be supportive to the appellant.

47. Dr Clarke had looked at the bundle provided by the appellant at the meeting in December 2005 but had not undertaken to respond to it before the February meeting where it would be followed up; however the February meeting never got going.

48. Dr Clarke formed the view that the appellant's reporting of two PCT officers [Mr Mason and Ms Goodwin] was totally inappropriate, but he did not know what the appellant had said to the police. His understanding was based on what others had said to him.

49. The records showed that there were difficulties between the appellant and the neighbouring GP practice. A reference panel considered those records and the concerns of the LPC representative to be soft evidence. Dr Clarke did not approach the GP's about such matters because that was not the purpose of the reference panel. It considered that the evidence and whether or not it was necessary to go into more depth. Dr Clarke did not form a view as to where the blame lay for the poor relationship between the GP practice and the appellant.

50. Dr Clarke accepted that, in relation to the incident concerning Dr Mohan's prescription of eye cream, that the appellant should have and did ring the GP to discuss the prescription. However the concern was about how the appellant spoke to the patient about the prescription. Dr Mohan was not approached for his account of events. This matter was one of a range of issues that the reference panel was looking at. The appellant had been helpful in the past in spotting prescribing issues . Pharmacists are a failsafe in the system. There could have been more of a dialogue between the GP practice and the appellant.

Ms E Walker
Primary Care Liaison Manager,
North Yorkshire and York Primary Care Trust

51. Ms Walker adopted her statement of 10 July 2007 together with the transcript of her evidence given at the respondent's panel hearing, as evidence in chief. Ms Walker is the first point of call for pharmacists and is responsible for pharmacy assessment visits. Extracts of her further oral evidence may be summarized as follows.

52. Ms Walker first had contact with the appellant in April 2006. At that time Ms Walker had not been told anything about the history of the appellant's contact with the PCT, but surmised that there had been difficulties and that was the reason why Craven PCT had become involved.

53. Ms Walker's experience of telephone contact with the appellant was that her tone was aggressive although she did not threaten violence. At times the appellant's telephone calls could be constructive. At other times the appellant would in the course of a telephone conversation become agitated shown by her talking fast and her voice building to a crescendo in terms of speed and volume.

Ms Sharon Sissons
Primary Care Manager,

North Yorkshire and York PCT

54. Ms Sissons adopted her statement of 10 July 2007 together with the transcript of her evidence given at the respondent's panel hearing, as evidence in chief. Ms Sissons was the senior team leader for health screening, patient and contractor services, responsible for say to day management of those departments. Extracts of her further oral evidence may be summarized as follows.

55. In 2005 the regulations in respect of pharmacists were such that they were required to provide information to the PCT on a number of matters. In September 2005 Ms Sissons had written to the appellant asking for duplicates of the required information to be forwarded because the PCT had been unable to establish that the original form had been received. On 7 November 2005 Ms Sissons telephoned the appellant to follow up her request for duplicates to be sent. Over the telephone the appellant became extremely angry and shouted so loudly that Ms Sissons had to hold the telephone away from her ear. The appellant said that correspondence should be directed through her solicitor. The appellant in the course of the call said that she had a witness to the telephone conversation.

56. On other occasions Ms Sissons has had telephone calls with the appellant where the appellant was angry and on further occasions when the appellant was reasonable.

57. At the time of the call on 7 November 2005 Ms Sissons was not aware that there was a dispute between the appellant and the PCT and that matters should be dealt with by written correspondence. However that was not a reason for the appellant to shout as she had. It was accepted that the required form was detailed and that it was inconvenient to the appellant to have to provide a duplicate. Ms Sissons made arrangements to pick up the form herself from the appellant.

Mr K McAleese
Non Executive Director,
North Yorkshire and York PCT

58. Mr McAleese adopted his statement of 28 November 2006 together with the transcript of his evidence given at the respondent's panel hearing subject to 2 corrections as set out at pages 36c and 36'o', as evidence in chief. Mr McAleese was a non executive director at Craven, Harrogate and Rural District PCT at the relevant time with responsibility for independent contractor performance. Extracts of his further oral evidence may be summarized as follows.

59. Mr McAleese saw his role as to ensure that the PCT acts reasonably and that disputes are handled in accordance with natural justice.

60. Craven PCT became involved with the appellant in November 2005 because it had been asked to take a fresh look at the relationship between the appellant and Selby and York PCT.

61. Mr McAleese saw the key issue as being a problematic interpersonal relationship and that further evidence was required as to the quality of the relationships with a view to finding a decision that was acceptable to all the parties. Mr McAleese was a lay member of the reference panel that considered the reports from Dr Clarke and others. The appellant did not attend such meetings.

62. Mr McAleese's knowledge of the case is based on the reports he has considered and what he has heard at panel meetings. The meetings were attended by a number of officers and a representative from the LPC. The view of the panel was that further evidence was required about the appellant's relationships with the PCT. At other panel meetings there was also discussion of the appellant's relationship with GPs, pharmacists, an district nurses.

Ms S Callicott
Primary Care Development Manager
Craven, Harrogate and Rural District PCT

63. Ms Callicott adopted her statement of February 2006 together with the transcript of her evidence given at the respondent's panel hearing, as evidence in chief. Ms Callicott was present at the meeting of 9 February 2006 at which the appellant threatened to pour a cup of hot water over Dr Clarke. Extracts of her further oral evidence may be summarized as follows.

64. The meeting of the 9 February 2006 was supposed to be supportive to the appellant. Dr Clarke started the meeting on that basis. It is accepted that the meeting would be stressful for the appellant. At the meeting, after about ten minutes, the appellant stood up quickly, said that she had had enough and lifted the cup of water over Dr Clarke's head. She looked anxious and angry as she was holding the cup. The water in the cup had been dispensed by a machine and at that time would have cooled. The incident was shocking.

65. It is accepted that Ms Callicott's statement is incorrectly dated as 8 February 2006.

Ms A Rayner,
Personal Assistant
North Yorkshire and York Primary Care Trust

66. Ms Rayner adopted her statement of 6 July 2007, as evidence in chief. At the relevant time Ms Rayner was personal assistant to Penny Jones the chief executive of Craven PCT and acting chief executive of Selby and York PCT. Extracts of her further oral evidence may be summarized as follows.

67. Ms Rayner was with the appellant after she left the meeting of 9 February 2006 at which she threatened to pour water over Dr Clarke. Ms Rayner was surprised at what had happened and tried to calm the appellant down.. the appellant did calm down and returned to the meeting.

68. In October 2005 ms Rayner recalled that the appellant had attended the chief executives offices with a view to acing an appointment to see her.

Mrs R Ainger,
Principal Pharmacist
North Yorkshire and York PCT

69. Mrs Ainger adopted her statement of 13 September 2007 together with the transcript of her evidence given at the respondent's panel hearing subject to one minor alteration, as evidence in chief. Mrs Ainger is responsible for managing the prescribing budget, effective use of medication and overseeing safe-handling and storage of some drugs. Extracts of her further oral evidence may be summarized as follows.

70. Mrs Ainger has had many dealings with the appellant since her appointment in 1999. Her experience of those dealings over the years is that they are time consuming, difficult and protracted. Some of the issues raised by the appellant were valid, but the way in which they were raised was not what one would necessarily expect from an independent contractor. For example, where there was a difference of opinion between a pharmacist and a GP, usually they work out that difference between themselves. However the with the appellant there was a lack of acceptance of the GP's opinion. She did not accept that a GP could prescribe medication outside its license in the light of the patient's individual circumstances and would not accept the GP's perspective.

71. Mrs Ainger's contact with the appellant occurred in waves. For some periods of time the appellant would not be in contact. At other times the level of contact was intense and repeated over a number of days and weeks. In the period prior to October 2004 the frequency of calls was at such a level that arrangements were made for a log of calls to be made as set out at pages 89 to 93 with entries starting on 1 October 2004.

72. Some of the issues that the appellant raised with the PCT were frivolous. For example in 2006 the appellant applied for a post with the PCT. This was surprising and bizarre given the circumstances and on going legal proceedings. The appellant was offered an interview. The appellant subsequently wrote in stating that she did not want the job. It appeared that she had had no intention of doing the job.

73. The PCT found contact with the appellant sad and frustrating. The PCT offered support and guidance to all pharmacists, but no one had been so frustrating as the appellant. The PCT had only a small team to deal with pharmacy matters and time taken with the appellant stopped the team from working on other matters relating to patient care and safety.

74. It is accepted that some of the issues raised by the appellant were matters properly raised and that the PCT remit extended to giving advice to pharmacists. It was proper for the appellant to raise an issue with Dr Mohan in prescribing timodine ointment for inflamed skin. The guidance on its use was to keep it away from the eyes. In prescribing timodine for use on the patients face the GP had exercised his professional judgment and should discuss it with the patient.

75. Mrs Ainger's concern about the timodine incident was not that the matter had been raised, but the manner in which the appellant had raised the matter with the patient. Dr Mohan felt undermined by the way in which the appellant had dealt with the issue. Mrs Ainger accepted that she was unable to say what words had been used by the appellant in her dealings with the patient. The matter should have been dealt with sensitively and it was not acceptable for the appellant to suggest to the patient that the GP had not prescribed appropriately. The GP subsequently prescribed different medication because he felt the patient had no confidence in him because of what the appellant had said. Dr Mohan had written the letter to Mrs Ainger on 13 January 2004 about the incident because he was concerned about how the situation had been dealt with.

76. Mrs Ainger had hoped to arrange a meeting between the appellant and the GP practice in order to improve relations between them, but a meeting could not be arranged. Mrs Ainger had been advised by her own manager, Kay Goodwin that it was not appropriate for her to meet with the appellant.

77. There had also been an incident between the appellant and Dr Bell-Syer in October 2002. Dr Bell- Syer said that he had been ranted at by the appellant. A note of the concerns suggested that the doctor had been challenged in front of patients. The issue was the verbal communication by the appellant was inappropriate.

Ms K Goodwin
Director of Strategic Partnerships
Selby and York Locality

78. Ms Goodwin adopted her statement of January 2007 together with the transcript of her evidence given at the respondent's panel hearing, as evidence in chief. Ms Goodwin has been employed as a general manager on a number of posts with the NHS and has experience in management of disputes. Extracts of her further oral evidence may be summarized as follows.

79. At various times the appellant required the PCT to communicate wither through either the ward councilor Mr MacDonald or her solicitors. This caused confusion for members of staff, who were concerned about whether or not they were doing the right thing in their dealings with her.

80. Ms Goodwin received a letter dated 28 September 2006 from the appellant's solicitor suggesting that Ms Goodwin had made defamatory remarks. Ms Goodwin was horrified. She believed legal action would be taken against her.

81. Over the years Ms Goodwin had had a supportive role with contractor's but not with the appellant.

82. Ms Goodwin was asked to mediate between the appellant and the local GP surgery. Two meetings were arranged but did not take place. On one occasion the appellant's mother was not well. The second arranged meeting may not have taken place through no fault of the appellant.

83. Two nurses at the practice had also raised concerns in writing about the appellant.

Dr Geddes
Medical Director
Selby and York locality

84. Dr Geddes adopted his statements of January 2007, subject to amendment of paragraph 26 and 31 October 2007, as evidence in chief. Dr Geddes also practices as GP as well as working as medical director. Dr Geddes became involved in the appellant's case in December 2004 at the request of the then chief executive Mr Clough. Extracts of his further oral evidence may be summarized as follows.

85. At the time of Dr Geddes becoming involved with the appellant there were concerns about the overwhelming level of correspondence with the appellant and the difficulty in managing it. The PCT had been unable to resolve the issues. Dr Geddes reviewed the correspondence and decided to offer the appellant support rather than see her as a vexatious complainant.

86. Dr Geddes first met the appellant on 28 April 2005. The meeting was to be with himself, the chief executive, Kay Goodwin and the appellant. The appellant thought that the meeting had been arranged with the chief executive only. Dr Geddes introduced himself to the appellant and explained his role. He said that the appellant and the others should meet together. The chief executive alone was not in position to deal with all the concerns raised by the appellant. The appellant became hostile, angry and frustrated. Her reaction to be told of the arrangements for the meeting were disproportionate. The appellant was shaking and anxious, her speech was hurried. The appellant was angry and spoke in a raised tone.

87. Dr Geddes next met the appellant on 2 June 2005 at the appellant's invitation. The meeting began at the pharmacy but with the agreement of Dr Geddes moved to the appellant's home nearby. The first part of their conversation was constructive. Dr Geddes wanted to understand the appellant's difficulties with the PCT and clarify what the PCT could do to address the issues.

88. Dr Geddes wanted to explore the issues and to consider whether the appellant's reaction to stress as demonstrated at the meeting of 28 April 2005 might have an adverse impact on patient safety and the appellant's own health. At the 2 June 2005 meeting Dr Geddes, on the basis of his review of the correspondence and discussions with the chief executive, had in mind that an occupational health assessment would assist. In looking at performance issues it was important routinely to address health needs as a matter of good practice. This view was confirmed by the appellant's disproportionate response to the events on 28 April 2005.

89. After about two hours into the meeting on 2 June 2005 Dr Geddes , having discussed the role of small independent contractors; the new pharmacy contract; and empathizing with the appellant on the basis of his own experience as GP , felt it was natural progression to suggest an occupation health assessment. The appellant became hostile and said that she would get a solicitor. This demonstrated a lack of insight into the levels of concern. On reflection Dr Geddes was of the view that the appellant's behaviour showed some level of paranoia.

90. Dr Geddes recalled that he had been told by David Gill, a member of the LPC, that the appellant had said to Gill that Dr Geddes' wanted to get into her knickers'. Dr Geddes was unable to recall the exact words used. His attention was drawn to a letter from the respondent's solicitors to the appellant dated 29 July 2005 in which the words ' he had the hots for you' were noted and the appellant's own record of events in the appellant's second bundle at page 122. Dr Geddes accepted that these words were more likely to be accurate of what was said.

91. Dr Geddes is of the view, which is not a clinical opinion, that the appellant displays traits, such as histrionic behaviour and labile response, which would be consistent with Borderline Personality type. An occupational health assessment would assist in this. Arrangements would be made for independent occupational health consultant to undertake the assessment. Dr Geddes would not prejudge how specifically the assessment would assist but it could look at issues of adaptations that the PCT could make and how to manage stress.

92. The documents from the appellant showed signs of stress. For example, the events referred at page 20 onwards of the respondent's bundle where the appellant refers to the system being reliant on smaller independents; the pharmacy being used as a dumping ground; the fiasco over faxes; and banging your head against the wall are all indicative of someone potentially under stress. The issue of stress is a matter for the occupational health physician to decide.

93. The occupational health assessment is a fundamental element in the assessment of overall safety and competence. Such issues also take account of for example the environment, behaviour, and clinical competence. The health element is one part of it. The PCT wished to be assured that there are no health concerns that would impact on patient safety, and if there were, that they were acted on.

94. Dr Geddes was directed to the appellant's complaint about him to the GMC. Dr Geddes accepted that he could have expressed himself better when explaining the sequence of events at paragraph 26 of his statement and accepted the GMC's reminder about not making misleading statements.

95. Dr Geddes has seen the strategic health authority report on the appellant's complaint about the events of 28 April 2005, 2 June 2005 and the suggestions that she should appoint a solicitor. The findings of the report showed that there were issues of miscommunication which are accepted by Dr Geddes and the chief executive. Dr Geddes at the time of the 28 April 2005 was not aware that the appellant was expecting to see the chief executive alone. Dr Geddes accepted that a change in those whom the appellant expected to meet might be stressful for the appellant; however it would be unrealistic for the appellant to expect the chief executive to deal with all the details on his own.

96. The occupational health assessment was offered at the June 2005 meeting because the appellant had shown signs that she was under stress at the April meeting and in correspondence. It was accepted that other pharmacists expressed concerns about the new pharmacy regulations, but that did not mean that they all needed an occupational health assessment. Dr Geddes did not form a clinical view about the issue of stress and the

appellant. Stress is useful but should not cross the boundary so that it affects professionalism.

97. The June 2005 meeting did not focus only on the PCT concerns but looked at many issues and challenges to small independent contractors over a 2 hour discussion.

98. Dr Geddes used the word paranoia in a non clinical sense to describe the appellant's behaviour. Paranoia is strong word describing a symptom not an illness: it is a tendency to feel persecuted. The appellant feels that an unfair and unjust position is being taken against her.

99. The proposal for an occupational health assessment does not imply that the appellant has mental health issues, and is usually seen as helpful. Dr Geddes has not experienced any other practitioner reacting against such a proposal in the same way as the appellant has done. The appellant had been upset and said that she would contact solicitors. Dr Geddes did not accept that it was an appropriate response. He expected a professional to understand the concerns in the context of a discussion. Solicitors might be appropriate in order to write a letter or where there was hearing. Dr Geddes has experience of receiving complaints as a GP. It is fundamental response to listen and to understand what is said., and then get advice. That approach is endorsed by the Royal colleges and NCAS.

100. The PCT had convened a reference panel in July 2005, where a decision was made that further investigation was required. The case was given an amber signal showing that further investigation was required. However the investigation did not progress because of the impasse with the appellant refusing to meet. There were no concerns about dispensing errors. Arrangements were then made for Craven PCT to take over the handling of the issues.

101. The trigger for the reference panel had been the complaints from the district nurses as set out in the respondents bundle from page 189 onwards. Dr Geddes had no further information about those complaints other than what was said in those documents. The concerns arising from those documents relate to the appellant's communication style and not the detail of the dispute about prescribing stockings. Dr Geddes accepted that no patients had complained about the appellant.

102. The behaviour described in the district nurses complaints mimicked the relationship behaviour of the appellant with the PCT. The complaints were soft evidence that there was unprofessional behaviour impacting on professional and clinical relationships. This came to the reference panel in order to decide whether to investigate or not. The reference panel saw this as an amber case so the next step was to investigate.

103. The investigation was not carried out because when the outcome of the meeting was communicated to the appellant she stated that all communication must go through her solicitor. The PCT adopted a softly softly approach because it was only soft evidence. However there followed a succession of letters from her solicitors and the process came to an impasse. A professional was expected to understand concerns and to take steps to improve.

104. The reference panel process at the time did not involve the practitioner at the initial stages. That was system inherited by Dr Geddes. The process now is to contact the practitioner before the meeting.

105. The reference panel considered the material and the context of a fractured relationship with the PCT. Dr Geddes also had direct experience of the appellant's behaviour at the meetings of April and June 2005. . the concerns of the district nurses took the issues into different arena because of the potential impact on patient care. . the

information needed careful evaluation and that included an occupational health assessment.

106. The process is set out in a flow chart at page 155 of the respondent's bundle. The process provides that anonymous letters would not be considered. The reference panel did not consider anonymous letters. The reference panel of 3 November 2005 was an extra –ordinary meeting of a type not usually convened. It was a response to the appointment of a new chief executive and was convened only to up date the position. It did not explore any issues. The chief executive took the view that a fresh start should be made and the matter was handed to Craven PCT. The reference panel did not meet again, although there was a formal handover meeting to Craven PCT on 25 January 2006.

Oral evidence on behalf of the appellant

107. Mr Reissner, following the close of evidence on behalf of the respondent, indicated that the appellant had elected not give oral evidence or to call oral evidence on her own behalf.

The Respondent's submissions

108. Mr McCartney, on behalf of the respondent, relied on his skeleton argument and made a number of further submissions that may be summarised as follows.

109. Over the course of the proceedings it now seemed to be said on behalf of the appellant that it was accepted that in considering the efficiency of services provided, a wider construction would be appropriate, without such terms being limited to the services of the appellant. It appeared to be also accepted by the appellant that the terms of service also referred to appropriate professional standards without specifically referring to the Ethics document issued by the RPSGB.

110. The respondent also accepted that other regulatory bodies may have a role to play in dealing with the appellant, but that such jurisdiction did not exclude the FHSAA or the PCT from exercising their powers.

111. The appellant had failed to give oral evidence. In cross examination care had been taken not to put any positive case on behalf of the appellant. The case had not been put by the appellant and therefore the respondent's witnesses had not had an opportunity to comment on the allegations being made against them. The appellant had not given oral evidence to support her position and therefore had not been cross examined. Nor had the appellant called any other witness to give oral evidence on her behalf. For example Dr Geddes had been subject to what he saw as an unsubstantiated and distressing allegation of, in words taken from the appellant's own written account, being *a pervert with the hots* for the appellant. These are matters which may affect the view the Panel takes of the evidence.

112. The prejudice to the efficiency of services arises in 3 ways. First, arising from the actual time wasted. The appellant s approach to issues is not proportionate to the matters in issue and she is unable to come to a resolution of those issues. The respondent's officers therefore have less time to deal with other contractors with a consequential effect of services.

113. Second, prejudice to the efficiency of services arises from concerns relating to clinical safety. It is accepted that the appellant has an extremely good clinical record; however the evidence shows that there are concerns about stress and the appellant's extreme and volatile behaviour, which in is worrying.

114. Third, prejudice to the efficiency of services arises from the behaviour of the appellant in dealing with patients and professionals which has the effect of

undermining in public confidence in the services being provided with inevitable consequences on the efficiency of services.

The submissions on behalf of the Appellant

115. Mr Reissner on behalf of the appellant relied on his skeleton argument and made further submissions which may be summarised as follows.

116. The appellant opposed the proposal that she undertake an occupational health assessment as a matter of principle. It is for the respondent to prove their case. The appellant's view is that the proceedings are unjustified and that it would be unreasonable to remove her from the list. The appellant's view is that the respondent has failed to investigate her concerns or justify the steps that they have taken.

117. The appellant's position as to the law is now broadly similar to that of the respondent's. However note should be taken that: the criteria for removal, with the wording *would be prejudicial,* looks to the future and should be distinguished from disciplinary matters where past conduct is the focus; a distinction should be drawn between matters that would be prejudicial to services which are provided by those on the list, and prejudice to the respondent in carrying out is administrative functions; and that, as set out in the appellant's skeleton argument, there were a number of matters that must be considered when deciding to remove.

118. Amongst the matters that must be considered are the actions of the appropriate regulatory body. It is not disputed that the roles of the various regulatory bodies are not mutually exclusive. In this case the events of 9 February 2008 where the appellant had threatened to pour water over Dr Clarke had been reported to the RPSGB. The society had not considered the matter to be one that required referral to its health committee and dealt with it by issuing advice on the basis that the appellant accepted the facts of the allegation.

119. The appellant's view is that she had no inkling that there were concerns about her until 2005 when she complained about the arrangements for the Christmas rota. The appellant had been upset by suggestions from Dr Geddes that the PCT had concerns about her and that she should be subject to an occupational health assessment.

120. The appellant had complained to the Strategic Health Authority about how she had been treated. The Strategic Health Authority had largely upheld her complaints and had made recommendations with a view to conciliation. The appellant's conduct should be viewed within the context that she expected her complaints to be dealt with as recommended by the Strategic health Authority. However the respondent through Dr Clarke had a different perspective and he had wanted to move matters on without intending to investigate the concerns of the appellant. The appellant met Dr Clarke on 13 December 2005 and gave him a bundle of documents with her concerns for him to consider. The appellant reasonably expected that by their next meeting on 9 February 2006 Dr Clarke would respond to her concerns; however he had not dealt with her concerns as set out in that bundle.

121. Mr Reissner then made submissions in respect of each of the allegations particularised by the respondent. It is not necessary to set out those submissions in detail. In brief Mr Reissner noted how some of the allegations had been amended: this typified the approach of the respondent in pursuing matters that they were unable to substantiate. The appellant had legitimately brought a number of issues mentioned in the allegations to the attention of respondent. That was a reasonable approach on the part of the appellant. The appellant had been criticized for not contacting Dr Mohan about his

prescription for eye cream, but the evidence showed that she had done so. The respondent had been quick to find fault with the appellant without investigation. The respondent had a closed mind in dealing with the appellant as evidenced by Dr Geddes description of the appellant as being paranoid. Many of the allegations did not go to the issue of prejudice to the efficiency of services.

122. Turning to evidential issues Mr. Reissner noted a number of matters. The respondent had failed to call a number of witnesses to give oral evidence. the respondent had relied on 'soft evidence' and had been process driven, rather than engaging in a proper investigation of the concerns and giving the appellant an opportunity to account for the allegations. As such the appellant had been painted into a corner and had felt the need to ask for communication to be directed through her solicitors. The appellant relied on the documents set out in the bundles. She had provided her own written statements. The appellant was also supported by references from a number of professionals.

123. In addition, in considering the appeal, due regard should be given to the age of the matters of which complaint is made.

124. The respondent submits that the appellant's management of stress is an issue which calls for an occupational health assessment. However all practitioners will be under stress, but it does not mean that their continued inclusion on the list would be prejudicial to services. No evidence has been produced to show that the number of the appellant's dispensing of prescriptions has been falling.

125. The respondent's view that an occupational health assessment would be supportive and lead to a resolution of the issues had not been successful. That was not the fault of the appellant. If the respondent had followed the recommendations of the Strategic Health Authority, the issues might have been resolved. If the respondent had been concerned about the effect of stress on the health of the appellant, then it is true to say that the appellant could have done without the stress of these proceedings. The appellant does not resile from her claim that the respondent is engaged in a *malevolent campaign of persecution and intimidation…* and that *there is a conspiracy to drum up a series of spurious and anonymous complains.*

Assessment of Evidence and Findings of Fact

126. The Panel considered all the evidence and the submissions of the representatives. It is not necessary for the Panel to make a finding in respect of each and every allegation particularized by the respondent. It is sufficient to make findings that are material to answering the question whether or not the criteria for contingent removal are proven.

127. The Panel turns first to an assessment of the principal witnesses relied on by the respondent Doctor Geddes, Doctor Clarke and Ms Ainger.

128. The Panel finds the evidence of Dr Geddes to be detailed, plausible and supported by documentation. Dr Geddes answered all the questions put to him directly and without evasion. The Panel finds Dr Geddes approach in oral evidence to be balanced and even handed. He acknowledged that in paragraph 26 of his statement that he had made a mistake as to the sequence of events. The Panel accepts as reasonable his explanation that in making that statement he had been working from memory rather than from documentation. The Panel finds that his account is materially consistent and the matters arising from paragraph 26 do not undermine his credibility.

129. Dr Geddes account of events of his meetings with the appellant on

28 April 2005 and 2 June 2005 were subject to very detailed cross examination. His replies were consistent and detailed. Dr Geddes accepted that his recall of the wording of the accusations against him in terms of ' he tried to get into the appellant's knickers' is less reliable than the more contemporaneous documentation which records the accusation in terms of his 'having the hots' for the appellant'. In any event, the Panel notes that the appellant herself does not dispute that she recorded that she '*voiced her opinion that the way Geddes was behaving towards her made him look like some sort of pervert who had the hots for her*'.

130. The appellant's claim about those events were not directly put to Dr Geddes. Further the appellant elected not to give oral evidence on these matters or at all. The Panel infers that the appellant's failure to give oral evidence on these and other matters, when considered in the context of the evidence as a whole, is because her own account, to the extent that it is in conflict with the respondent's evidence, would not withstand scrutiny.

131. The Panel therefore finds that evidence of Dr Geddes is credible and prefers his evidence to that of the appellant for the reasons given above.

132. The Panel finds that the same can be said of the other witnesses relied on by the respondent. Dr Clarke's account is consistent and plausible. The Panel finds that he showed a balanced approach in giving oral evidence. In oral evidence he accepted that he had been mistaken in suggesting that the appellant had not contacted the GP in relation to prescribing timodine. His evidence as to the appellant threatening to pour water over him at a meeting on 9 February 2006 is not disputed by the appellant. The Panel finds Dr Clarke to be a credible witness.

133. The Panel finds that the evidence of Rachel Ainger is credible. In oral evidence she gave a detailed and consistent account. Her recall of the extent and nature of appellant's telephone calls was supported by documentary evidence in the form of a log of calls.

134. Dealing briefly with the other witnesses called by the respondent, Mr Mason, Ms King, Ms Walker, Ms Sissons, Ms Goodwin, Mr McAleese, Ms Callicott and Ms Rayner, the Panel finds that their evidence was consistent and plausible and that in cross examination nothing of significance emerged that would lead to a finding that their evidence had been fatally undermined. The Panel finds that their evidence is credible

135. Looking at the evidence as a whole and taking account of the appellant's failure to give evidence, as noted above, the Panel makes the following findings of fact.

136. For a significant number of years from 2002 if not before, the appellant had telephone contact with the respondent and its predecessors at a level that was much greater than contact with other pharmacists. The dealings between the PCTs and the appellant, extending over a number of years were time consuming, protracted and difficult.

137. A number of officers from the various PCTs, such as Mrs Ainger, Ms Walker and Ms Sissons, have had experience of having telephone calls with the appellant in which the appellant's manner was aggressive and loud.

138. In February 2002 the appellant became loud and aggressive when dealing with an issue relating to disposal of waste at her pharmacy.

139. In October 2002 a local GP, Dr Bell-Syer reported to the PCT that he had felt undermined by the appellant.

140. In January 2004 Dr Mohan reported that he felt undermined by the way the appellant dealt with his prescribing of timodine cream for a patient.

141. In 2004 the PCT were so concerned about the calls from the appellant that arrangements were made for them to be logged. Sometimes the appellant would not contact the PCT for a period of weeks, at other times there was intense contact. For example: in October 2004, 4 telephone calls were logged; in December 2004, 2 telephone calls were logged; in March 2007, 16 telephone calls were logged.

142. The frequency and manner of the calls prompted the respondent's officers to put in place arrangements especially for the appellant. The Panel finds that the measures are resource intensive and considerably in excess of that expended in respect of other pharmacists.

143. The appellant engaged in correspondence with the respondent at such a level, regarding a range of issues and in such a manner, that the respondent arranged for correspondence to be channeled through, and personally considered by, the chief executive. In December 2004 the PCT's medical director became involved at the direction of the chief executive because of the overwhelming correspondence from the appellant.

144. On 28 April 2005 the appellant attended the respondent's offices expecting to meet with the chief executive. On being told that other officers, including Dr Geddes would be in attendance the appellant became hostile, angry and frustrated. The appellant shook and was anxious, her speech was hurried. The appellant was angry and spoke in a raised tone.

145. On 2 June 2005 the appellant and Dr Geddes met, at the appellant's invitation, at the appellant's home. In the course of the meeting the Dr Geddes raised the issue of the appellant undertaking an occupational health assessment. The appellant became hostile and said that she would get a solicitor.

146. On 1 July 2005 the respondent received two reports from two community staff nurses in which it was said that the appellant had been agitated and irate in her interaction with the nurses and that the appellant had been rude to patients.

147. On 22 July 2005 the appellant complained to the strategic health authority about the meetings of 28 April 2005 and 2 June 2005. It subsequently made recommendations in or around November 2005 with a view to achieving conciliation including: that the PCT acknowledge and apologise for added distress to the appellant due to a misunderstanding of and mix up over the meeting on 28 April 2005; that Dr Geddes apologise for any distress caused to the appellant, however unwitting; that the chief executive and appellant meet on a one to one basis or as agreed to discuss the appellant's issues on a general basis only as a matter of courtesy; and that arrangements be made for the appellant to work with a peer or a mentor to address the concerns of PCT.

148. On 27 July 2005 the appellant attended a local meeting of pharmacists at the Crown Hotel in Boroughbridge in order to discuss the new pharmacy contract. The appellant voiced her opinion that the way Dr Geddes ' *was behaving towards her made him look like some sort of pervert who had the hots for her*'. Dr Geddes took no action on this matter save to pass it to the legal services manager. A letter from the respondent's solicitor's was sent to the appellant on 29 July 2005 indicating that the comments if said were defamatory.

149. At various times the appellant required the PCT to communicate with her only through her ward councillor Mr Macdonald or her solicitors. At times this resulted in difficulties for PCT officers. For example in on 7 November 2005 Ms Sissons was unaware of

the appellant's stipulation in this regard and as a result experienced a telephone call with the appellant during which the appellant shouted and was angry.

150. In or around November 2005 the strategic health authority issued its report, as noted above.

151. In or around December 2005 arrangements were made for Craven and Harrogate PCT rather than Selby and York PCT to manage communication with the appellant. Arrangements were also made for Mrs Ainger, as principal pharmacist, to direct calls from the appellant to the director of public health, Dr Clarke or the legal services manager, Mr Mason.

152. On 13 December 2005, in implementing the arrangements for the involvement of Craven PCT and in the context of the strategic health authority report the appellant and a supporter attended a meeting at the PCT's offices. At the meeting, Dr Clarke said that he wished to explore the appellant's concerns and the PCTs concerns. Dr Clarke took the view that he would not read documents before the meeting in order to approach the matter with a 'fresh pair of eyes'. The appellant within a short period of the opening of the meeting stood up and said that she had had enough and left the meeting.

153. On 9 February 2006 a follow up meeting to that of 13 December 2005 was held. Attenders at the meeting included the appellant and Dr Clarke. After about 10 minutes the appellant stood up, positioned herself behind Dr Clarke and held a cup of hot water over his head. The other members of the meeting told the appellant no to pour it over Dr Clarke. The appellant put the cup down and left the meeting.

154. In 2006, despite the history of the relationship between the respondent and appellant, the appellant applied for a job with the PCT as a practice based pharmacist. The appellant was offered a job interview but declined to attend. The appellant had no intention of working for the respondent.

155. The appellant has made allegations and formal complaints about 3 senior officers. In or around July 2006 the appellant made a complaint to the police that the PCT generally and Mr Mason personally, were harassing her. The police after receiving information from Mr Mason concluded that it was not a matter requiring police action.

156. In the course of making their inquiries into the appellant's allegations of harassment by the PCT, the police contacted Ms Kay Goodwin. As a result, the appellant, through her solicitors issued a letter dated 26 September 2006, in which it was stated that Ms Goodwin had said to the investigating officer that the appellant 'would be shut down within a fortnight'. The letter went onto say that 'before taking action' Ms Goodwin was to be given an opportunity to confirm whether she had made the statement. Ms Goodwin denied the allegation and the letter was passed to Mr Mason for reply. No further action ensued.

157. On 16 October 2008 the appellant filed a complaint about Dr Geddes with the GMC. It was alleged that Dr Geddes had been (1) aggressive and bullying; (2) had made a dishonest statement; (3) had convened a reference panel meeting as a result of her complaint about his behaviour; and (4) that he had expressed an opinion about the appellant's health without her consent. In respect of complaints (1), (3) and (4) the GMC found that there was insufficient evidence to support the allegations. In relation to allegation (2), Dr Geddes admitted that his statements were confusing and the GMC found that there was insufficient evidence to show that Dr Geddes intentionally engaged in deception. The GMC issued a reminder to Dr Geddes to do his 'best to make sure that any documents written or signed are not false or misleading'.

Decision and Reasons

158. Looking at the totality of the evidence and applying the criteria for removal from the pharmaceutical list and in the light of the above findings, the Panel directs that the appellant be contingently removed from the respondent's list because her continued inclusion would be prejudicial to the efficiency of the services which those included in the list undertake to provide.

159. The condition imposed with a view to removing any prejudice to the efficiency of the services in question is as follows

the appellant, within 8 weeks of promulgation of the FHSAA determination, agrees to be examined by an independent consultant occupational health physician and that, should such assessment identify any health concerns, that the PCT receives assurance that these concerns can and are being addressed

160. The reasons for the Panel's decision are as follows.

161. The Panel considered the competing submissions as to the ambit of the phrase ' efficiency of the services'. It was contended on behalf of the appellant that it should be narrowly construed and that a distinction be drawn between the administrative convenience of the respondent and prejudice to the relevant services. The respondent submits that a wider interpretation should be applied.

162. The Panel is of the view that the term should be widely construed to the extent that it embraces not only the actual pharmaceutical services provided by individual practitioners on the list but also the supporting activities undertaken by the respondent to enable those services to be provided. The Panel is of the view that the concept of efficiency of services necessarily extends to the measures taken to enable the services to be provided and that to construe the wording otherwise would be to introduce an artificial divide. Practitioners do not work in a vacuum and the actions of practitioners which impact on the system of provision necessarily has an effect on efficiency of the services.

163. The Panel also takes the view that the words 'would be prejudicial' looks to the future provision of services. In this context the Panel finds that past events are an important guide to likely future events. The Panel finds that no material evidence has been adduced to show that there have been any significant changes in circumstances that would show the concerns raised in this appeal have been ameliorated. In this respect the Panel also notes that the date and the passage of time since the incidents is a mandatory consideration in coming to a decision.

164. For convenience the Panel finds helpful the respondent's submission that issues relating to the prejudice to the efficiency of services may be grouped under the broad heads: (a) time actually wasted; (b) concerns relating to clinical safety; (c) undermining of public confidence in services.

Efficiency and time wasted

165. The Panel finds that the evidence shows that a very significant amount of resource has been expended on the appellant, to a degree that is not comparable with that expended on other pharmacists. The respondent has had to make special arrangements for telephone calls to be taken from the appellant and directed to designated officers. The respondent has had to co-ordinate a response to the extensive correspondence originated by the appellant, to the extent that the chief executive was monitoring and authorising communications. The appellant has also raised issues about practice with the PCT that ordinarily would be resolved without the involvement of the PCT.

166. A further example of the appellant's engagement with the PCT leading to time being wasted is her application to be a practice based pharmacist with the PCT in 2006. Mrs Ainger thought that the application was *bizarre* given the history of the relationship between the appellant and the PCT. The PCT necessarily expended officer time in dealing with the appellant's application. As noted above the appellant declined the invitation of an interview. The appellant has not put forward a reasonable explanation for making such an application.

167. In addition to these matters the appellant has made a number of official complaints to the police and to the GMC. After apparently brief inquiries, the police took no further action. The GMC found there was insufficient evidence warranting action save that Dr Geddes be reminded of his duty to ensure accuracy in any statements he made. These are further matters that required officer time and ultimately the complaints were shown not to have a sound evidential base.

168. All these matters have an impact on the efficiency of the services which those on the list undertake to provide. There is an 'opportunity' cost' involved. In simple terms this means the expenditure of officer time on these matters means that less time is spent on matters relating to care and patient safety, engaging in clinical governance matters or in advising other pharmacists.

Efficiency, clinical issues, patient safety and public confidence

169. The Panel finds that there are well founded concerns about the appellant's reaction to stressful situations and the appellant's relationship with other professionals. The Panel finds that these concerns go to the issue of prejudice to the efficiency of services.

170. In general terms the Panel finds that in many instances it is the manner in which the appellant deals with situations which is of concern, rather than the substance of the issue. The evidence shows that the appellant has become hostile and aggressive on many occasions as set out in the findings of fact above.

171. Specifically, the most striking example is the appellant's threat to pour water over the director of public health by standing behind him and holding a cup over him, but there are other examples, such as the appellant's reaction at her meetings with Dr Geddes and the appellant's dealings in relation to the disposal of waste, as well as numerous other telephone calls.

172. The Panel notes here that the water incident of 9 February 2006 was reported to the Royal Pharmaceutical Society of Great Britain. The appellant has not put forward any explanation for such behaviour, either to this Panel or, from the Panel's reading of the documents, to the society. The society decided to deal with matter by issuing advice on the basis of the appellant's acceptance of the occurrence of the events subject to complaint and the Panel accordingly take this into account.

173. The Panel finds that these are matters that properly form a basis for considering how the appellant reacts to stress which may be addressed through an occupational health assessment. Clearly if stress were to be identified as a feature within the context of an occupational health assessment, then measures and strategies might be identified that would enable services to be provided more efficiently. The assessment would be of benefit to both the appellant, not least in terms of her own health, and to respondent, not least by providing assurance as to patient safety.

174. The evidence also shows that the manner in which the appellant deals with other professionals and the public are a proper matter for concern. Concerns about the appellant have been expressed by two GPs and two district nurses. The appellant has decided not to give oral evidence on these matters. This Panel's findings of fact on these matters do not go beyond the fact that professionals have expressed concerns.

175. Nevertheless, such matters are significant in assessing risk to patient safety and as such they are material to the judgment that the appellant's continued inclusion on the list would be prejudicial. It is not contended that the appellant has been dispensing in error, but as Mr Reissner has noted, the criteria refer to the future; and in that sense a risk assessment necessarily considers both the likelihood of occurrence and the consequences of future events, notwithstanding that in the past there have been no dispensing errors.

176. The appellant whilst declining to give oral evidence or call witnesses on her behalf makes a number of criticisms of the respondent. Given our findings of fact it is not necessary to deal with all those matters in this determination. The centre piece of the appellant's case is that she has been involved in a *malevolent campaign of persecution and intimidation….* and that *there is a conspiracy to drum up a series of spurious and anonymous complains*. The Panel finds that the evidence shows that such a view is not objectively well founded. The thrust of many of the submissions made on behalf of the appellant was to the effect that the facts were not disputed, but that the appellant's actions were justified. The Panel rejects those submissions. The behaviours set out in the findings of fact speak for themselves.

177. The Panel notes that the appellant has put forward a number of documents from supporters. The Panel attaches relatively little weight to them when considering the totality of the evidence. The appellant's supporters did not witness the primary matters on which findings of fact are made and their views do not go to the issue of the prejudice of the efficiency of services, given the Panel's findings of fact.

178. The Panel finds that the respondent has real grounds for concern and has attempted to engage with the appellant with a view to genuinely supporting her and in gaining assurance as to patient safety.

179. In these circumstances the respondent's proposals for an independent occupational health assessment are made with a view to removing any prejudice to the efficiency of the services in question.

Summary

180. The Panel directs that Ms Brompton be contingently removed from the North Yorkshire and York Primary Care Trust Primary Care Trust's pharmaceutical list on condition that the appellant, within 8 weeks of promulgation of the FHSAA determination, agrees to be examined by an independent consultant occupational health physician and that, should such assessment identify any health concerns, that the PCT receives assurance that these concerns can and are being addressed.

181. In accordance with Rule 42 (5) of the Rules the Panel hereby gives notice that a party to these proceedings can appeal this decision under Sec 11 Tribunals & Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days of receipt of this decision.

Signed Date

Mr J D Atkinson, Chairman