The First-tier Tribunal
(Health, Education and Social Care Chamber)
Primary Health Lists

No: PHL/15212

IN THE MATTER OF THE NATIONAL HEALTH SERVICE ACT 2006
And in the Matter of the NATIONAL HEALTH SERVICE (PERFORMERS LISTS) REGULATIONS 2004

Miss Siobhan Goodrich: Legal Member
Dr Douglas Kwan: Professional Member
Mr Bill Nelson: General Member

Heard on 29th March 2010

BETWEEN:

Dr VINOD MOUDGIL
(General Medical Council Registration Number 2355568) **Appellant**

and

WANDSWORTH PRIMARY CARE TRUST
Respondent

Representation
For the Appellant: Mr Simon Cridland, Counsel, instructed by RadcliffesLeBrasseur
For the Respondent: Mr Whiting, Capsticks

DETERMINATION on NATIONAL DISQUALIFICATION

The Background

1. In 2009 the FHSAA panel (hereafter “the panel”) heard evidence over six days in the appeal of Dr Moudgil against the Respondent’s decision to remove his name from the list of NHS performers in primary care services maintained by

the Trust. The panel reserved its decision and did not hear submissions on the potential order of national disqualification pending our decision on the facts.

2. By written determination (hereafter "the substantive decision") dated 16th October 2009 the panel made findings of fact and decided the Dr Moudgil was unsuitable to be included in list of the Respondent PCT. Directions were given to enable a hearing on the issue of national disqualification to be arranged.

3. Dr Moudgil has not appealed the substantive decision.

4. We should say that the panel for the substantive hearing consisted of the same members save that the professional member was Dr Sadek. The parties were advised that Dr Sadek could not sit and did not raise any objection to Dr Kwan sitting as a new professional member.

5. The power to make an order for national disqualification is now to be found in Section 159 of the National Health Service Act 2006 as well as in the National Health Service (Performers Lists) Regulations 2004. It arises whenever an appeal against removal made by a practitioner is dismissed. It is a freestanding power and is not dependent upon any application by the PCT.

The Appellant's case on National Disqualification.

6. The Appellant's case is set out in the skeleton argument and was developed in oral submissions. He essentially contends that national disqualification is not necessary on grounds of patient protection and would be unfair and disproportionate because it would preclude him from retraining and deprive him of the opportunity to earn his living as a GP. Patient safety would be adequately protected because he would only be permitted to practise if the General Medical Counsel ("the GMC") determined that he was able to practise safely.

7. Mr Cridland reminded us that Dr Moudgil's registration as a medical practitioner has been suspended by the GMC on an interim basis since June 2007. He awaits a hearing at the GMC in respect of his fitness to practice which is listed in mid August 2010/early September 2010. He underwent a GMC performance assessment in July 2009 in which concerns were identified. Mr Cridland submits that there is no prospect that the GMC will allow Dr Moudgil to return to unrestricted practice. He hopes to retrain by participation in the Deanery's Induction and Refresher scheme ("I&R"). To do so he will first have to pass the Multiple Choice Test ("the MCQ") and the Simulated Surgery ("the OSCE").

8. Mr Cridland submits that there is no need to impose national disqualification: the Deanery and the GMC are "the gatekeepers" and any concerns in respect of patient safety are thereby met. The minimum that Dr Moudgil can expect is the imposition of conditions by the GMC that he can only practice by way of participation in the I&R scheme and under the supervision of a GP trainer.

9. Dr Moudgil undertook the Fresh Start course in July 2009. He has attended courses for general practitioners at St George's Hospital and has undertaken other study.

10. The London Deanery is prepared to assist Dr Moudgil. He has overcome a very significant hurdle because Dr Hartley, his educational supervisor, has agreed to act as his GP trainer/supervisor within the scheme. Supervision is a fluid concept and the level depends upon what the vocational trainer considers is necessary. It is usually close to begin with and then becomes less as retraining proceeds. Any concerns that the Tribunal had as to whether Dr Moudgil is safe to practise even on a supervised basis are met because in order to take up the place on the I&R scheme Dr Moudgil would have first to pass the MCQ and the OSCE.

11. In answer to the Tribunal's inquiry Mr Cridland produced further documentation to which we will refer hereafter.

The Respondent's submissions.

12. In its submissions the PCT referred to the Department of Health Guidance "Delivering Quality in Primary Care". Paragraph 40.2 states that national disqualification may be imposed if the facts that gave rise to original decision are so serious that they warrant disqualification.

13. Paragraph 40.4 states that:
"PCTs should recognise the benefits of a national disqualification both for protecting the interests of patients and for saving NHS resources. Unless the ground for removal... are essentially local, it would be normal to give serious consideration to such an application."

14. The facts in this case were plainly serious and wide ranging as set out in the substantive decision which was then summarised.

15. In his oral submissions Mr Whiting asked the Tribunal to note that that the Appellant had not produced his personal development plan ("PDP"). Further the evidence relied on by the Appellant did not mention any of the panel's concerns set out in the substantive determination or how such matters had been or would be addressed.

The Correspondence with the London Deanery.

16. The letter from the Appellant's solicitors to the London Deanery dated 10th September 2009 refers to the *"depressing results"* of the GMC performance assessment and requested *"a stark appraisal of the prospects of (Dr Moudgil) ever being able to return to general practice at the age of 62 with GMC assessors effectively saying that he is irremediable."* The GP performance unit of the London Deanery offered to assist Dr Moudgil if he contacted them directly.

17. In his letter of 3rd December 2009 Dr Mendl of the London Deanery sets out an account of the meeting held that day.

18. We have been provided with a copy of the covering letter that Dr Moudgil wrote to the Deanery on 5th March 2010 in advance of the next meeting that took place in 11th March 2010. This sets out the aim of his personal development plan (PDP). He hopes that following a successful application to the GMC to lift his suspension he would join and complete the Deanery's I&R scheme by August 2010 and January 2011.

19. Dr Mendl's letter of 11th March 2010 is an account of the meeting with Dr Moudgil held that day. He suggested some changes to the road map devised by Dr Moudgil with particular reference to the timescale and advised that Dr Moudgil would need to pass the Simulated Surgery (OSCE)as well as the MCQ and convince the GMC to lift his suspension in order to be accepted for a place on the I&R scheme. This scheme involves 12 months of fully funded supervised half time practice, a weekly educational workshop and private study.

20. We noted that Dr Mendl gave advice in relation to preparation for the Simulated Surgery assessment and suggested a textbook on consultation skills. He also said that, more crucially, he would also suggest stepping up the frequency and length of the sessions with Dr Ian Hartley. He had earlier noted that Dr Moudgil had met Dr Hartley on two occasions, each for about 30 minutes.

21. So far as a supervised placement is concerned we were informed that Dr Hartley has now agreed to provide this to Dr Moudgil.

The Decision on National Disqualification

22. We considered all of the material placed before us and the submissions of both representatives.

23. The Appellant's submissions in relation to proportionality are centred on the basis that the GMC holds the ultimate key in relation to patient safety because no PCT could admit Dr Moudgil to its list unless and until the GMC has decided that he is fit to practice. Mr Cridland urges upon us that it is inconceivable that the GMC would determine that Dr Moudgil is fit to practice unless stringent conditions were imposed in relation to retraining or supervised practice. It would therefore be unfair, unnecessary and disproportionate to direct national disqualification in these circumstances because the risk to patient safety would be covered by the existing interim suspension order and the GMC conditions that will be imposed. The "catch 22" is that a national disqualification will prevent Dr Moudgil from being able to undergo retraining.

24. In our view the *effect* of the Appellant's submissions is to almost treat the GMC as a review body to the Tribunal's decision or, perhaps more accurately, to request that we effectively delegate the issue of national disqualification from NHS primary care lists to the GMC.

25. The two bodies have separate functions although there is inevitable overlap in terms of the core public interest in patient safety. At the GMC hearing the

Fitness to Practice panel will make its own findings on the basis of the evidence before it and will from its own views as to whether the Appellant's fitness to practice "is impaired". If so, it will decide what action, if any, should be taken in respect of his registration *as a registered medical practitioner.*

26. The FHSAA panel has already determined that the Appellant is unsuitable to be included in the NHS performers' list maintained by the Respondent and has directed his removal from that list. The new Tribunal is seized of whether, in the light of the findings made, it is appropriate that the Appellant be permitted to seek to gain entry to the list of other NHS primary care trusts across England and Wales. It is true that a favourable outcome in the forthcoming GMC proceedings could result in the Appellant's continued registration with the GMC which, absent an order for national disqualification, would enable him to apply for inclusion in the list of another PCT so as to enable him to retrain. (A GMC decision could also enable him to work as a registered medical practitioner in other capacities that are not dependent upon inclusion on a PCT list). The fact is, however, that even the GMC were to reach entirely different conclusions as to the facts alleged in its proceedings or make a judgement as to outcome that is more favourable to Dr Moudgil, the decision and judgement of this panel in relation to the substantive issues still stands. Moreover, it is this body, rather than the GMC, that is given the responsibility for deciding whether a practitioner should be disqualified from applying *for inclusion in the primary care lists of PCTs throughout England and Wales.*

27. If an order for national disqualification is not made the Appellant will be at liberty to seek to apply to any PCT for inclusion in its list. As a matter of law, any future application the Appellant might make to any PCT would have to be considered on its individual merits. The consideration of any application absorbs PCT time and resources. In practical terms the application would only be made by Dr Moudgil if the GMC were to reach a different view from the FHSSA panel. The PCT in its initial decision making would thus be faced with two different decisions by two bodies on the same essential subject matter. A refusal to include by a PCT would entitle Dr Moudgil to a right of appeal to this Tribunal which entitles the Appellant to a redetermination. It is usual for both parties to be represented in an appeal. It would doubtless be argued on Dr Moudgil's behalf that this veryTribunal, despite the original findings, had not considered it appropriate to nationally disqualify the Appellant, and had effectively decided to leave the issue to the GMC. It should also be noted that any PCT who refused to include the Appellant could itself make an application to the Tribunal for national disqualification.

28. On the other hand, if an order for national disqualification is made Dr Moudgil will not be able to take advantage of the opportunity to retrain as a general practitioner. The decision in relation to national disqualification is thus determinative of his future as a performer delivering primary care services in the NHS.

29. We refer to the substantive decision. The Appellant did not accept all the facts alleged. He contended at the substantive hearing that he was not unsuitable

and the inefficiencies his practice could be remedied by a period of about three months retraining. Having made detailed findings of fact we rejected that submission and concluded that he was unsuitable to provide primary care services for the Respondent PCT. It is unnecessary to repeat our findings of fact or analysis of the evidence. The full reasons as to why we came to the conclusion that Dr Moudgil was unsuitable to be a primary care performer are set out at paragraphs 113 to 120.

30. It is, of course, the case that conditions cannot be imposed where the finding is that of unsuitability.

31. We also considered inefficiency at paragraphs 121 and 122 in the alternative. We concluded that it was very unlikely that the habits that Dr Moudgil had acquired would be eradicated by any period of training even if the training were judged to have been successful. We also considered that, whatever training or supervision were to be put in place by way of conditions, Dr Moudgil's singular approach would again emerge because his approach to practice was based on deep seated and irremediable characteristics: hence our conclusion in respect of unsuitability.

32. Effectively, the same argument was advanced at the substantive hearing as is now before this tribunal - albeit that the only matter that then called for decision was the removal from the list of the Respondent PCT. In effect Mr Cridland in his submissions asks us to act in a manner inconsistent with the determination in respect of unsuitability and to now defer the assessment of risk to the GMC. There is however some new evidence before this Tribunal and we have considered this carefully in the context of the national disqualification issue now before us.

33. We have considered the fact that Dr Moudgil has secured an offer of retraining from the Deanery. Mr Cridland urged upon us the fact that Dr Hartley has agreed to act as Dr Moudgil's supervisor was a significant factor because it is well known that it is extremely difficult for a general practitioner to find another GP to act as a trainer/supervisor. We do not doubt that this is so but the fact is that Dr Moudgil will first have to pass the MSQ and OSCE and persuade the GMC to allow him to practise before he could be accepted to the I&R scheme. We have not been informed of the results of the performance assessment undertaken by the GMC in June 2009 but it is apparent from the correspondence that these were poor.

34. We noted that Dr Moudgil had only seen Dr Hartley twice by March 2010. We infer from his letter that Dr Mendl considered that Dr Moudgil's overall timescale was somewhat unrealistic. We were also informed that Dr Mendl had not been provided with the substantive decision of the FHSAA panel. We recognise the Deanery's role is that of postgraduate education and, in that context, the views formed by the FHSAA panel may be of little interest or significance in its consideration of how it could assist Dr Moudgil educationally. There is no evidence before us that the Deanery has made a specific qualitative assessment in relation to Dr Moudgil's prospects of success in passing the necessary assessments

35. In our view the evidence now before us and the contingent offer of retraining do not address the fundamental reasons for which Dr Moudgil was removed from the Respondent's list. In the substantive decision the panel expressed the view that this was not a case where the practitioner had become deskilled or out of date with the standards of ordinary practice, but rather one where that he pursued his own instincts and beliefs without regard to ordinary standards or an evidence based approach. We emphasise that the FHSAA panel having considered a great deal of evidence, including that of Dr Moudgil, as well as the evidence of two experts, came to the very clear conclusion that Dr Moudgil was unsuitable to provide primary care services for the Respondent PCT: the deficiencies in his practice were irremediable because of his conduct, lack of insight, idiosyncratic attitude, lack of logicality and deep seated characteristics. The panel considered that his continued practice, even if subject to retraining or other conditions such as supervision, posed a clear risk to patient safety and the public interest in the efficiency in primary care services in the NHS.

36. We consider that there are no geographical or locality issues involved in the facts we found. In these circumstances an order for national disqualification may be justified in a removal case in order to prevent a practitioner from applying to another PCT but each case must be considered on its facts. The facts which gave rise to the decision to remove Dr Moudgil from the Respondent's list were undoubtedly serious as evidenced by the detailed findings made. We recognise that we must exercise discretion and that an order for National disqualification is a very serious matter.

37. We have considered again the substantive findings and the issue of national disqualification in the light of current circumstances. There is little evidence that suggests that there has been any real change on the part of Dr Moudgil in relation to his insight or attitude nor has it been seriously suggested that the FHSAA panel were not entitled to reach the views that it did. At its highest the evidence in respect of retraining amounts to a different view taken by others concerning remediability based on an educational perspective.

38. The issue is whether it is fair, necessary and proportionate to make an order for national disqualification in all the circumstances. We weighed the effects of an order for national disqualification upon the Appellant against the public interest, including the protection of patients and the efficient use of NHS resources. We are aware that any order made will have profound and long lasting effects upon the Appellant's professional and personal life. Dr Moudgil qualified at the University of Punjab in 1971. He has given long service to the NHS first in hospital practice from 1977 until 1992 and, thereafter until 2007 in general practice. In practical terms, and given the Appellant's age, an order for national disqualification will almost certainly bring his ability to work as an NHS general practitioner to an end in the long term (irrespective of the length of the review period). It may even impact adversely upon his ability to practice as a registered medical practitioner in an NHS hospital setting or even outside the NHS. We are aware of his personal family circumstances and have taken into account the effect of a national disqualification on his ability to provide for

himself and his family and the consequent effect that this may have upon his family life. Having balanced all these factors, we nonetheless consider it fair, necessary and proportionate to make an order for national disqualification because the public interest in patient safety and well being and the efficient use of resources outweighs Dr Moudgil's interests.

The Direction

39. Accordingly, we direct pursuant to Section 159 of the National Health Service Act 2006 that the Appellant, (General Medical Council Registration Number 2355568), is nationally disqualified from inclusion in:
    (i) the supplementary lists prepared by each Primary Care Trust;
    (ii) the lists of persons performing primary care services prepared by each primary Care Trust under Section 91 of the Act and
    (iii) the lists corresponding to the lists mentioned above prepared by each Primary Care Trust and each Local Health Board under or by virtue of the National Health Service (Wales) Act 2006.

The Direction as to the Review period

40. Under Regulation 18A (8) (a) the disqualified practitioner may not apply for a review of national disqualification until two years has elapsed from the date of its imposition. At such a review the FHSAA (now the Tribunal) may confirm or revoke the disqualification. Regulation 18 A is subject to Regulation 19 which provides as follows:
    "The period for review shall be the different period specified below instead of that in regulation 18A (8) (a) where the circumstances are that-
    (a) on making a decision to impose a national disqualification the FHSAA states that it is of the opinion that the criminal or professional conduct of the performer is such that there is no realistic prospect of a further review being successful, if held within the period specified in regulation 18A (8) (a), in which case the reference to "two years" in that provision shall be a reference to five years;…"

41. We have considered **Swain v Hillman [2001] 1 All ER 91** where in the context of the court's power to summarily dispose of claims in civil proceedings and the overriding objective Lord Woolf MR stated:
    "The words 'no real prospect of succeeding' do not need any amplification, they speak for themselves. The word 'real' distinguishes fanciful prospects of success or, as [Counsel] submits, they direct the court to the need to see whether there is a "realistic" as opposed to a "fanciful" prospect of success."

42. The issue at stake for the Appellant in this context is his potential ability to work as a general medical practitioner, delivering NHS primary care services, after a minimum of two years following national disqualification. It could be said that the factors that we must balance when exercising discretion and acting proportionately are subtly different from consideration of national disqualification itself. Dr Moudgil will have to apply to this Tribunal to ask it to bring the order to an end. The PCT need not be a party although it may seek to be heard. It could be said that the burden on tribunal resources in hearing a future application is not substantial. The right of appeal would be on a point

of law only.

43. In our view the balance to be struck in this context is between Dr Moudgil's interests and the general public interest in the efficient use of tribunal resources and the overall interests of justice. No matter how slim the prospects of success may be we are mindful that it is a very serious matter indeed to preclude any access to the Tribunal to enable a fair adjudication in respect of any change that might possibly occur.

44. The FHSAA panel made clear findings that Dr Moudgil's conduct and practice was irremediable. In all the circumstances of this case we consider that the prospects of success can properly be characterised as fanciful. We consider that it fair and proportionate to express the opinion that his professional conduct is such that there is no realistic prospect of a further review being successful, if held within two years. It follows that the period for review under the regulations is five years.

Further Directions

45. We direct that a copy of this decision is sent to the Secretary of State for the Department of Health, the National Assembly of Wales, the Scottish Executive, the Northern Ireland Executive and the Registrar of the General Medical Council.

Rights of Review and/or Appeal.

46. The Appellant is hereby notified of the right to appeal this decision under section 11 of the Tribunals Courts and Enforcement Act 2007. He also has the right to seek a review under section 9 of the Act. Pursuant to paragraph 46 of the Tribunal Procedure (First- tier Tribunal) Health, Education and Social Care Chamber) Rules 2008 (SI 2008/2699) a person seeking permission to appeal must make a written application to the Tribunal no later than 28 days after the date that this decision was sent to the person making the application for review and/or permission to appeal.

Siobhan Goodrich

Judge of the First-tier Tribunal

4th May 2010