IN THE FAMILY HEALTH SERVICES APPEALS AUTHORITY

Case No: 13266

MS M LEWIS Chairman
DR S SHARMA Professional Member
MRS V BARDUCCI Member

Between

DR WILLIAM DAVID KAY
(GMC no: 2337102)

Appellant

AND

HAMPSHIRE PRIMARY CARE TRUST
(FORMERLY BLACKWATER VALLEY & HART PCT)

Respondent

DECISION AND REASONS

Appeal

1. This is an appeal by Dr William David Kay against the decision by what is now Hampshire Primary Care Trust, communicated by its letter dated 19 July 2006 to remove him from its Performers' List under Regulation 10 (4) (a) of the NHS (Performers' List) Regulations 2004 ('the Regulations').

2. The appeal was heard on 9 November 2006 at the NHS Litigation Authority. The PCT was represented by Miss Richler-Potts. Dr Kay appeared and represented himself.

3. The PCT called Ms Helen Clanchy, Interim Director of Primary and Community Care, Mr John Parker, former chair of the PCT and Dr Steven Clarke who had carried out an investigation for the PCT.

Decision

4. Our unanimous decision is to dismiss the appeal and direct the removal of Dr Kay's name from the Performers' List of this PCT.

Background

5. The Appellant has been a General Practitioner in Farnborough, Hampshire since 1984. The history of this case is fully set out in the PCT response and supporting documents and chronology. The PCT chronology sets out historic concerns dating back to 2002 when the PCT Chief Executive asked Occupational Health to formally medically examine Dr Kay under paragraph 25 (8) of the NHS (GMS) Regulations to address various problems in occupational health reports. For reasons of brevity and more particularly because the Appellant accepted that his performance had been impaired by alcohol between 2000 and 2004, it is not necessary to set out that aspect of the history in any detail. The Appellant is a recovering alcoholic who had not had a drink since July 2004. The PCT accepted that was the position.

6. However, there were also concerns about Dr Kay's prescribing practice but this was treated separately from health concerns. Meetings took place on 11 June 2004 and a further meeting on 28 June, both attended by Helen Clanchy, then Director of Primary Care, Dr Stuart and Natasha Dymond a human resource manager looking into concerns that had been raised over an ectopic pregnancy. In the light of that the PCT suspended the Appellant from their Performers' List with effect from 18 June 2004.

7. It was in those circumstances that a referral was made to Wessex Deanery for a clinical assessment carried out by Dr Steven Clarke the PCT's deputy PEC chair.

8. Pursuant to Dr Clarke's report there was a referral to the NCAA who didn't feel able to take on a case of this nature, advising the PCT to make a referral to the GMC. This occurred on 7 December 2004. Unfortunately The GMC assessment did not take place until 7 June 2005.

9. The contractor performance group met on 21 February 2006. On 28 February Helen Clanchy and Natasha Dymond met with the Appellant to notify him that it was the intention of the PCT to remove him from the Performers' List pursuant to Regulation 10 (4) (a) on the efficiency ground.

10. An oral hearing took place on 15 May 2006, chaired by John Parker, PCT Chair. That hearing had to be adjourned part way through. The Appellant referred to the contents of a letter, which had not been placed before the Panel showing that he was is in correspondence with the GMC regarding the proposed conditions. The Panel thought it therefore only appropriate to adjourn the hearing so that they had all relevant information. The Panel reconvened on 12 July 2006. The Panel was of the view that the level of support required to supervise the Appellant would prejudice the efficiency of primary medical services. They thought it unlikely that he would find a suitable place in Kent, Surrey, Sussex or Wessex, the area covered by the PCT. The Panel were also concerned regarding the Appellant's lack of insight into the level of supervision and retraining required to address the comprehensive list of concerns highlighted by the GMC assessment report. That remains the PCT position.

<u>The Law</u>

11. This appeal is brought pursuant to Section 49M of the National Health Service Act 1977 as amended and Regulation 15 of the Regulations, by virtue of which it proceeds by way of a re-determination of the PCT's decision, and this Panel may make any decision which the Primary Care Trust could have made.

12. The National Health Service (Performers' List) Regulations 2004 provides as follows:

i. **Regulation 10 (3) and (4)**

The Primary Care Trust may remove a performer from the Performers' List where any of the conditions set out in paragraph (4) is satisfied.

The conditions mentioned in paragraph (4) are that:

(a) His continued inclusion in its Performers' List would be prejudicial to the efficiency of the services which those included in the relevant Performers' List perform ('an efficiency case');

ii. **Regulation 11**

Where a Primary Care Trust is considering whether to remove the performer from its Performers' List under Regulation 10 (3) (4) (a) ('an efficiency case') it shall take into consideration:

(a) The nature of any incident which was prejudicial to the efficiency of the services, which the performer performs;
(b) The length of time since the last incident occurred and since the investigation into which it was concluded;
(c) Any action taken by any licensing, regulatory or other body, the Police or Court as a result of any such incident;
(d) The nature of the incident and whether there is a likely risk to patients;
(e) Whether the performer ever failed to comply with the request to undertake an assessment by the NCAA on or before 31 March 2004 or thereafter by the NPSA;
(f) Whether he has previously failed to supply information, make a declaration or comply with an undertaking required on inclusion in the list;
(g) Whether he has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any List or equivalent List and if so the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or the equivalent body for such action.

ii. **Regulation 12**

In an efficiency case or fraud case the PCT may, instead of deciding to remove a performer from its Performers' List decide to remove him contingently.

If it so decides it must impose such conditions as it may decide on his including in its Performers' List with a view to

(a) Removing any prejudice to the efficiency of the service in question;

Preliminary Matters

13. At the outset of the hearing the Appellant confirmed that he was not represented and he had not sought advice either as to these proceedings or in relation to the PCT oral hearing.

14. Ms Richler-Potts provided a copy of the letter from the General Medical Council to Ms Clanchy dated 1 June 2006 stating the Appellant's undertakings pursuant to the performance assessment. Dr. Kay raised no objections, as he was aware of the contents of the letter.

15. We were concerned that save for the grounds of appeal no written evidence had been received from Dr Kay. At the hearing he submitted the following documents: -

i. Letter to Dr. Kay from Dr Richard Weaver Deputy Director of Postgraduate GP Education Severn and Wessex Deanery dated 28 September 2006.
ii. Letter dated 5 May 2006 from Dr Churcher-Brown Consultant in Occupational Psychiatry to GMC Fitness to Practise Directorate confirming Dr Kay's

abstinence from alcohol and that in his view it was no longer necessary for Dr Kay to remain under supervision.

16. Ms Richler-Potts did not object to that late evidence, accepting Dr Kay should have a full opportunity to put his case. However, the writer of the letter was not present to be questioned so the contents of the letter were untested. The PCT had not seen that letter before the hearing.

17. Dr Kay requested that the witnesses remain outside the hearing, as that happened in other proceedings. We refused that application. We did not consider his reasons strong enough to outweigh the normal course in these proceedings of witnesses remaining in the hearing, particularly as Dr Kay had not committed his case to writing prior to the hearing as the procedure rules require. We were assisted by the witnesses remaining in the hearing and being able to instruct Ms Richler-Potts as new evidence emerged.

Grounds of Appeal

18. Dr Kay confirmed that he did not wish to proceed with ground 3: that the oral hearing panel of the Primary Care Trust was not within the law. The two grounds of appeal on which he proceeded were that:

1. The General Medical Council's decision was that I was fit to practice with restrictions. The Primary Care Trust initially said that the findings of the General Medical Council were irrelevant, then decided to postpone the oral hearing until they could assess the General Medical Council's findings.

2. The Primary Care Trust contend that it would be difficult to place me in a post because of the General Medical Council's conditions. Because something is difficult does not mean that it cannot be done.

19. The PCT response on grounds 1 and 2 is as follows:

28.1 It is within the remit of the PCT to reach a decision differently to that of the GMC. Whilst initially the PCT were concerned with the GMC report itself and felt that it alone raised sufficient concerns to justify the removal of the Appellant from their Performers' List the Appellant's introduction of the GMC Conditions at the first Oral Hearing on 15 May 2006 caused the Oral Hearing Panel to revisit the conditions. It would have been erroneous of the Panel not to take those conditions into consideration.

28.2 It is within the remit of the PCT to determine that the level of support, retraining and supervision required would prejudice the efficiency of primary medical services. It is accepted that simply because something is difficult does not mean that it cannot be done but the PCT must ensure an efficient safe service is provided to patients and they were entitled to conclude that the Appellant could not do so, with such onerous conditions.

The Evidence

20. In determining this appeal we have had regard to all the written, oral and documentary evidence.

Summary of GMC Assessment

21. The summary set out at pages 71-72 of the GMC report (PCT documents pages 112 and 113) acknowledged that Dr Kay co-operated completely. It was acknowledged that Dr Kay could assess patients appropriately and had knowledge of investigations and was

capable of keeping good records. He had adequate knowledge of how to treat emergencies. He was willing to attend courses and undergo appraisals. He was said to be quiet and shy but never rude or discourteous and his staff were loyal towards him.

22. Whilst the assessment team found positive findings, the following significant problems were noted:

- Although Dr Kay knows theoretically how to assess patients properly there is evidence that he doesn't always do so.
- Relevant investigations are not always performed.
- Dr Kay has an inappropriately high level of antibiotic prescribing. He may be prescribing to patient demand, especially where addicts were concerned. There is some evidence that his treatment of addicts is below standard.
- Dr Kay could not justify his frequent use of new drugs. He is unaware of, or ignores, local prescribing guidelines.
- Dr Kay is unduly influenced by the pharmaceutical industry.
- There is some evidence of some evidence of failure to treat or refer appropriately.
- Poor communication with others can be a problem.
- Dr Kay's record keeping can be brief with only negative findings recorded. Investigations are not always recorded in the notes and at times there are significant omissions.
- There is no evidence that Dr Kay has a learning plan. His knowledge regarding hypertension and diabetes is out of date.
- His preparation for appraisal was poor.
- Dr Kay admits that he does no audit or performance review though he would seem to have the capability to do so.
- Though not necessarily a problem Dr Kay has a quiet and reticent manner. There is evidence that this may change if he has been drinking. His health problems would appear to be compounding a natural shyness and reticence.

23. The GMC Performance Committee recommended that the following conditions were attached:

- Dr Kay should not work in isolation but in a supportive environment where he can have appropriate mentorship and support.
- Dr Kay should not at present be involved in the care of addicts.
- Before returning to work with the limitations as above Dr Kay must demonstrate that his health issues have been successfully addressed. Whilst working he should have appropriate health surveillance.

Whilst working Dr Kay must address the following issues:

- Dr Kay must ensure that he prescribes appropriately and brings his knowledge up to date.
- Dr Kay must ensure that his record of keeping is of an acceptable standard.
- Dr Kay must improve his communication skills especially with patients. His consultation skills must improve.
- In order to achieve the above, Dr Kay will need a proper learning programme and appropriate learning support.

24. We first heard the evidence of Helen Clanchy who adopted her statement (R 20). Subject to an amendment in paragraph 9, which refers to the GMC assessment report. That showed that the peer review had looked at 15 areas of performance. An acceptable judgement was made in 2 areas, 7 areas were given as cause for concern, 4 areas were given as unacceptable (not acceptable) and in 2 areas there was no overall judgement made. She had come into post in March 2002. The GMC route was taken after concern about a patient who made a complaint in the 'ectopic pregnancy case'. On reading the GMC report she was concerned as to how the conditions laid down could be supported and achieved by a

GP worked independently. The function of the GMC was different. They looked at registration not performance. She was concerned that at the Oral Panel Hearing Dr Kay had not presented as very forthcoming. She didn't gain a strong sense that he saw the need for retraining.

25. The PCT's area as previously constituted was such that Dr Kay should have been referred by the GMC to the Kent, Surrey and Sussex Deanery. However she was aware that geographic boundaries were not strictly applied so that referrals were made to the Severn and Wessex Deanery. Had she seen the letter earlier she would have had a large number of questions to ask as how any retraining would be implemented, particularly as she understood the retraining practices were in Bristol.

26. Dr Kay asked Miss Clanchy to set out her background and her qualifications, which she did. Her background is in social work and general managerial roles. She agreed that the two-year delay after the referral had been made to the GMC was unfortunate. With the benefit of hindsight the NCCA could have been sidestepped and a direct referral made to the GMC. When re-examined, she said funding was not the sole issue but the opportunity cost. It was a question of who would carry out the retraining when the conditions were so wide ranging.

27. We next heard from Dr Steven Clarke who adopted his statement at R32. He confirmed he had no personal or professional dealings with Dr Kay prior to carrying out his assessment. He felt the GMC report confirmed his own concerns albeit it expanded areas he had not been able to investigate. For him a key question was whether Dr. Kay was able to put his knowledge into practice. He was concerned that he took the path of least resistance including over-prescribing of controlled drugs. The test competence results (PCT bundle page 84 onwards) were of concern. On the extended matching questions Dr Kay's score was 69.5, which was above the minimum acceptable of 68.68, so barely acceptable. Likewise his overall score of 72% for GP assessed OSCE was just about acceptable. Of particular concern was his score of 37% in the simulated surgery overall score. Whilst he accepted that Dr Kay might well have been nervous so might the 120 volunteer General Practitioners who took part in the trial. Alcohol was not the only issue. There were also issues about his style and behaviour. He was concerned that there had been very little information until the letter from the Severn and Wessex Deanery, which to him suggested that Dr Kay seemed to act in isolation.

28. When questioned by Dr Kay he agreed that the GMC report page 110 which referred to him not using English as his first language was curious as Dr. Kay is a Scot. In his statement he referred to a “retina detachment case” where a complaint had been made about Dr. Kay. . He agreed with Dr Kay that another GP might also have missed the condition; in what was he acknowledged a complicated complaint. His concern was Dr Kay's initial poor note keeping and his imprecise response when the PCT alerted him to the complaint. Dr. Clarke drew particular attention to the fact that there was no increase in prescribing statins, in accordance with a health directive. He acknowledged that the practice did not have many elderly patients with chronic conditions but his concerns about prescribing levels in the practice were referred to after discussion with the prescribing advisor who would have taken account of such outlay factors. He agreed it was possible for GPs to be rehabilitated subsequent to GMC proceedings and had knowledge of GPs within the area where this has happened.

29. We then heard from Mr Parker. He described the Appellant's approach at the oral hearing he had chaired as being rather cool and distant. He agreed that this might have been due to the stress of the situation. He was concerned that the GMC assessment threw up areas of concern that one would not expect of a practising GP. He did not think that the conditions set by the GMC were achievable with regard to the limited number of training places within the area and the amount of resources this would take up. Thought had been given as to whether a contingent removal was appropriate but this begged the same question as to the need for conditions.

30. When questioned by Dr Kay as to whether his was a political appointment Mr Parker confirmed that he had been appointed by the Independent Appointments Commission. The Panel had been concerned that Dr Kay did not appear to have taken on board the

seriousness of his training needs and had not put before them any intention or plans to take on training.

31. Dr Kay when giving oral evidence set out his background and his qualifications. He spent some time in medical practice in the air force until 1984 when he took up full time practice in Farnborough. We also learnt that his wife and daughter are doctors. He is a member of his Methodist church. He was sued once in 1996 and that had settled out of court. He has been a teetotaller since July 2004. Whilst he made no excuses he referred to the death of his brother in 2000 and his mother in 2002 as impacting upon him. Since that time he has sought support through AA meetings and a group for British doctors and dentists who have addictions. He is also a member of the International Doctors Alcoholics Anonymous Group. He has attended 3 annual conferences in Britain and this year a conference in Minneapolis on addictive behaviour. He had also paid privately to see a consultant psychologist and psychiatrist at the Woking Priory Hospital. He had found cognitive behavioural therapy helpful. Dr Churcher-Brown was the successor to his initial health screen with Dr Fleming pursuant to an earlier GMC condition of 2004.

32. He had attended lunch time lectures at the Royal Surrey County Hospital. He confirmed that his approach to Dr. Weaver at Severn and Wessex Deanery in September 2006 was the first approach he had made. We quote from his letter in some detail, as it raised a number of questions from us and Miss Richler Potts. It states:

> *Your long term plans are to retire from substantive NHS Posts with the possibility of undertaking alternative work within the NHS or locum work. There is a possibility you will retire completely from all NHS work but not for a couple of years and hence a Retraining programme would be entirely appropriate to meet your needs.*
>
> *We discussed the various options available to you and I would suggest that you should be looking at a six months full time Returners Programme or the equivalent part time. This means that you should apply for the current round of GP Returners which will be partly funded by the Trainer's Grant but will not include a salary. To do so you will need to sit the MCQ being held early in November details of which have been outlined on our web site. If you are not successful at gaining a Returners Grant the other option would be to look at a self-funding route and we discussed the implication of this.*
>
> *Should you be successful at gaining at Returners Grant you would be required to undertake a six month placement as mentioned above and your training plan would be based on a detailed educational needs assessment, informed by the GMC report. You will be required to undertake three of the four elements of Summative assessment during this time which will include the MCQ basic knowledge test, video consultation skills assessment and the detailed Trainer's review and report.*

33. We thought it helpful to ask Dr Kay a number of questions to help him put his case. Dr Kay confirmed that he took the MCQ test last week and expects the results in a few weeks. The medical member thought it appropriate to refer raise a question as had already been pointed out by Dr Clarke, that within NHS guidelines that a Returners Programme would normally be those returning to work after a break. A typical example would be a woman returning to work after a career break for family reasons Dr. Kay conceded that he would not be suitable for the Returners route and that he would require retraining. We were concerned that the letter was not clear as to which route Dr Weaver was suggesting. We clarified that no trainer has been appointed. . Dr Kay agreed that there would be a difference between taking somebody on to train by way of updating their knowledge and where they were working under GMC conditions.

34. The GMC report (page 81) had highlighted a lack of interaction with his colleagues. He said that this was because most of them were locums and he hadn't had much cause to have professional dealings. He had not approached the Medical Defence Union for assistance as he had stopped paying his fees when he had switched to being a salaried GP

within his practice. He was a member of the BMA but had not sought advice from them or the local medical committee.

35. Ms Richler-Potts then asked questions by way of cross examination. Dr Kay agreed that he had not approached the Severn and Wessex Deanery before September 2006. He had put together a personal development plan as requested by the GMC within three months, but they had returned it as it had not been drawn up in consultation with the Deanery. Ms Richler-Potts pressed him as to why funding was an issue, if he had agreed to and could afford to self fund. Dr Kay appeared to be trying the funded route first, which is why he had taken the MCQ test. Dr Kay had attended several conferences on addictive medicine but none in simulated surgeries or communication issues. Dr Kay stressed that it was difficult to access training courses whilst he wasn't actually practising.

Submissions

36. Ms Richler-Potts submitted that Dr Weaver's letter highlighted the difference in the functions between a Deanery and a PCT. There was no clear evidence on which either the PCT or we could conclude that a training programme could be put into place. It was of concern that Dr Kay had only just begun to address the concerns of the PCT. No evidence had been put before the PCT in the summer and only now had preliminary steps been taken. Even within the larger newly constituted Hampshire PCT the PCT could not see how it could meet the GMC's conditions.

37. Dr Kay stressed that the Performers Committee had not seen fit to refer him to the Fitness to Perform Committee. He reiterated his primary position that the GMC had found him fit to practise under conditions. It would be difficult for him to meet these alone, as he was not in practice. He had done his best by reading magazines and going to lectures. If he was not on the Performers' List he would not get a training position and the only option would be for him to retire and look for some other branch of medicine in which to work subject to the conditions the GMC had attached.

Conclusion and Reasons:

38. The Panel accepts that the PCT has conducted a very full assessment over a long period of time from 2002 onwards., including a referral to the GMC. We accept that they have spent a considerable amount of resources already in assessing Dr Kay. This case highlights the difference in the roles of the GMC Fitness to Practice Directorate, the PCT and Deaneries. The GMC has a regulatory function for all doctors including those working for a PCT. where. The Deanery is responsible for local education programme for GPs.

39. Having considered all the evidence we find that the PCT have proved their case. We conclude that the intensity of level of support the Appellant would require would compromise the efficient running of the General Medical Services within the PCT area. We had firmly in mind Dr Kay's ground of appeal: the fact that something is either difficult or even expensive does not make out the efficiency ground. However, we accept the PCT having reviewed this case on a number of occasions can see no route within its own resources to meet the conditions recommended by the GMC. The level of monitoring and supervision that would be required is very high.

40. It is not for Dr. Kay to make out his case. It is for the PCT to make out their case on a balance of probabilities. However, we were concerned that having made this appeal with an opportunity to have the matter decided by an independent appeal body, Dr. Kay filed very limited evidence and only on the morning of the hearing. We found it surprising that he mounted so little challenge to the PCT position, which he was fully aware of through the Oral Hearing and the papers filed in this appeal. We can only decide the case on the basis of the evidence at the date of the hearing and Dr.Kay did not put that evidence before us. That was despite the opportunity afforded by the extra time since the Oral Hearing to investigate other

training options. Whilst acknowledging the difficulties that Dr Kay may have had in presenting his own case, legal advice and support from professional organisations has been available to him at all times. He is not without means.

41. We find that there is still reason to find that Dr. Kay has not fully acknowledged the need for further retraining or how serious the concerns raised in both the report of Dr. Clarke and the GMC were. He relies on the Condition set by the GMC and has undertaken to comply with them. However he has not complied with the undertaking to file a Personal Development Plan set in consultation with the Deanery. It is of concern that the approach to the Severn and Wessex Deanery was made so late. The position of the PCT is that another PCT might be able to accommodate that re-training programme. We spent time investigating the letter from the Severn and Wessex Deanery, which raised more issues than it answered. We would describe this as a preliminary approach by Dr Kay to that Deanery. Dr Kay conceded that there is a difference between a Retraining scheme and a Returners scheme, terms that appear inter changeably in the letter. He accepted that he would not be a suitable candidate for a Returners scheme. There was no evidence that a Retraining contract is reasonably likely within the foreseeable future. We are enforced in that conclusion that, as acknowledged by Dr. Kay, the stringent conditions laid down by the GMC would make finding a trainer more difficult.

42. We find that Dr. Kay has a lack of insight into the level of supervision/retraining required to address the comprehensive list of concerns outlined in the assessment report and requirements of the GMC. That finding is enforced by events that have occurred subsequent to the Panel hearing of the PCT in July 2006. He has not actively sought out training options or very actively engaged in this appeal process.

43. That finding should be balanced by an acknowledgement that Dr. Kay has remained teetotal since July 2004. Much of his evidence focussed on his efforts to seek support for and address his alcohol addiction. He frankly and to his credit acknowledged, the negative effects alcohol had on his performance. However the PCT had always addressed the issues of his health and other performance issues separately. The GMC report was carried out June 2005 nearly a year after Dr. Kay became teetotal.

44. Having independently reviewed the evidence we agree that the level of support required to supervise the Appellant would prejudice the efficiency of primary medical services, in view of the Appellant not being in a position to return to his previous surgery, and the unlikelihood of finding a suitable place in Kent, Surrey, Sussex and with only a speculative possibility in Severn and Wessex. We share the PCTs concern regarding the Appellant's lack of insight into the level of supervision and retraining required to address the comprehensive list of concerns highlighted by the GMC report.

45. The Panel has considered contingent removal. The Panel find that this is not an appropriate case in which to direct contingent removal. The Panel find the Appellant would not be able to be supervised or monitored satisfactorily. For the same reasons we uphold removal on efficiency grounds.

THE PANEL DIRECTS THAT:

46. Dr. Kay is removed from Hampshire PCT Perfomers' List on the grounds that his continued inclusion in its Performers' List would be prejudicial to the efficiency of the services which those included in the relevant Performers' List perform.

47. Wither party to these proceedings has the right to appeal this decision under and by virtue of Section 11 Tribunals and Inquiries Act 1992 by lodging a Notice Of Appeal in the Royal Courts of Justice, The Strand, London WC"A 2LL within 28 days of receipt of this decision.

Ms M E Lewis
Chair
14m November 2006