CASE NO. FHS/13750

IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

Mr D Pratt - Chair
Dr R Rathi - Professional Member
Mr R Rhodes - Member

BETWEEN:

DR SYED KHADRI
(GMC No. 1557369)

Appellant

AND

NEWCASTLE PRIMARY CARE TRUST

Respondent

DECISION AND REASONS

APPEAL

1. This is an appeal by Dr Syed Khadri (Dr Khadri) against a decision by Newcastle Primary Care Trust (the PCT), communicated by its letter dated 19 March 2007, to remove him from its Performers List ("the List") under Regulation 10 of the NHS (Performers List) Regulations 2004 ("the Regulations") on the grounds that his continued inclusion in the List would be prejudicial to the efficiency of the service and the safety of patients.
2. The appeal was heard over three days from Friday 24 August to Wednesday 29 August at the FHSAA headquarters, Harrogate. Dr Khadri was represented by Mr Neil Davy of Counsel, instructed by RadcliffesLeBrasseur, solicitors, and the PCT by Mr Andrew Post of Counsel, instructed by Hempsons, solicitors.

DECISION

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

REASONS

The PCT decision under appeal

4. Following an oral hearing on 15 March 2007 to review Dr Khadri's then current suspension under Regulation 14 of the 2004 Regulations, and consider his removal or contingent removal from the List, the PCT gave its formal decision and reasons by letter dated 19 March 2007. Its decision (set out in paragraph 1 above) was expressed to be for the following reasons:
    a. "Poor clinical knowledge (as evidenced in the report from the Northern Deanery).
    b. Inability to retrain (as evidenced in the report from the Northern Deanery).

c. The extensive level of conditions that would need to be put in place to allow you to practice [*sic*]."

In reaching this decision we were minded to consider the findings of the NCAS report which was further supported by the conclusions of the Postgraduate Institute for Medicine and Dentistry.

Before reaching a conclusion that removal was the appropriate course of action the panel considered the option of Contingent Removal but decided there were no adequate conditions that could be imposed with any measure of confidence, that would address the areas of concern that would not make your working life in General Practice impractical."

The grounds of appeal

5. By a Notice of Appeal dated 12 April 2007 Dr Khadri set out three grounds of appeal or matters of complaint:
    a. Various matters of alleged procedural unfairness, centred on a refusal to adjourn in light of what was alleged to be inadequate time to consider evidence served from the Northern Deanery.
    b. The PCT Panel wrongly took into account information conveyed to the Chairman by the Deanery and not previously disclosed to Dr Khadri.
    c. The PCT Panel attached excessive weight to the evidence presented by the Investigating Officer and failed to take into account that Dr Khadri had insufficient opportunity to respond to it.

    In all the circumstances the decision was unfair, unreasonable and disproportionate and Dr Khadri was not given a fair hearing
6. In the event this Panel was not concerned to consider allegations of procedural unfairness before the PCT, since Mr Davy properly conceded that this appeal proceeded as a redetermination, in which the burden lay on the PCT to prove its case, and that, absent any continuing prejudice to which he could point, procedural unfairness at the PCT stage was irrelevant to this appeal. Thus (a) and (b) fell away and (c) was relevant only to the extent we were invited to balance other evidence against that of the Investigating Officer and reach a different conclusion.
7. By his skeleton argument, Dr Khadri invited this Panel to substitute a decision for contingent removal, subject to conditions that: (i) he comply with such training/ professional development requirements as identified by the NCAS assessment, and (ii) that he should undergo a further neuropsychological assessment of his cognitive function.
8. Dr Khadri's case as outlined in his skeleton argument, was that he should be given the opportunity to make further investigations regarding options for retraining. This position was developed in his witness statement. For present purpose the relevant part of that document was paragraph 7:

"I have not worked since my name was suspended from the Performers' List in March 2005. I have no intention of returning to work until such time as I have complied with the recommendations of NCAS and until my practice has achieved an acceptable standard. *I accept that my work is currently below the standard required to practice as a GP and that I require a period of retraining.* I am very keen to undergo such retraining and feel confident that I can get my standard back to the standard I had during my 31 years of practice." [emphasis added]

9. The short issue between the parties at the hearing was whether we could be satisfied that the PCT had proved that the continued inclusion of Dr Khadri on its Performers' List would be prejudicial to the efficiency of those services, so that it was appropriate to remove him outright, or whether he should be removed contingently, by the imposition of conditions on his registration with a view to removing any such prejudice.
10. At the outset of the hearing the PCT limited its case to a consideration of Dr Khadri's clinical performance (knowledge and skills and their application) and we were therefore invited by Mr Davy not to take into account issues such as practice management. We adopted this approach, save where such issues are a necessary and integral part of clinical performance (such as record keeping and making referrals).

<u>The relevant law</u>

11. The parties were in agreement as to the applicable law:
    a. This appeal proceeds by way of redetermination of the PCT's decision (Section 49M (3) and Regulation 15 (1) of the 2004 Regulations).
    b. We may make any decision which the PCT could have made (Section 49M (4) National Health Services Act 1977 and Regulation 15 (3) of the 2004 Regulations).
    c. By Regulation 10 (3) of the 2004 Regulations, a performer may be removed from the List where any of the conditions in Regulation 10 (4) are satisfied, including:
        (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").
    d. Regulations 11 (5), 11 (6) and 11 (7) set out criteria which are to be taken into account in determining an efficiency case.
    e. The burden of proving the case is on the PCT.
    f. The standard of proof (as both parties agree in the particular circumstances of this case) is the civil standard. We have asked ourselves, as Mr Davy invited us to do, whether we are satisfied that the facts or allegations are proved on the balance of probabilities.
    g. In an efficiency case we may, instead of deciding to remove the performer from the List, decide to remove him contingently (Regulation 12 (1) of the Regulations).

h. By Regulation 12 (2):

"If [the Panel] so decides, it must impose such conditions as it may decide on his inclusion in [the List] with a view to –

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

Preliminary issues and documentary evidence available

12. The Panel issued directions as to service of documents, witness statements and skeleton arguments, and having regard to the case advanced by Dr Khadri that he wished to explore retraining opportunities including those outside the Northern Deanery we directed:

"*In the event that the Appellant desires to argue at the hearing of this appeal that he has been, or is likely to be, accepted for retraining other than under the auspices of the Post Graduate Deanery, Newcastle upon Tyne, he shall provide to the Respondent and to the FHSAA, full particulars of each and every such retraining scheme by no later than 4 pm on 27 July 2007."*

In the event, no such particulars were provided prior to or during this hearing, save to the extent that an inconclusive telephone contact had been made with a Deanery in the north of Scotland over the Bank Holiday weekend in the middle of this hearing.

13. Pursuant to those directions the parties agreed a full and helpful chronology of events, to which we referred and incorporate into these reasons.

14. At the start of the hearing, the parties agreed to exclude the evidence of a witness whose statement had been served, and agreed that others could be read. The documents available and taken into account by this Panel were therefore:

a. The bundle described as "Case Papers", paginated A 1 to 78 (from the Appellant) and R 1 to R8 (from the PCT).

b. The following witness statement from the Appellant:

i. Dr Khadri (dated 31 July 2007) with exhibits SK 1 and SK2, comprising a copy timetable for GP refresher sessions offered through "doctorupdate.net" in September 2007, and various CPD accredited courses available through the BMJ and other organisations in October – December 2007.

c. The following witness statements from the Respondent:

i. Dr Neil Morris (dated 2 August 2007) with 25 Exhibits, comprising extensive correspondence, an assessment report from NCAS, his investigating officer's report, and documents from the Northern Deanery concerning a summative assessment of Dr Khadri by Multiple Choice Questions (MCQ);

ii. Mr Paul Chapman (Tyne and Wear Contractor Services Agency) dated 30 July 2007; this was agreed to be receivable by us as a written statement,

subject to agreement that paragraph 8 was an expression of Mr Chapman's opinion.

iii. Two statements of Dr James Harrison dated respectively 27 July 2007 (with two exhibited letters) and 22 August 2007, the latter being late served and admitted by agreement.

iv. Dr Hamish Paterson (Consultant Occupational Health Physician) dated 30 July 2007 with one exhibited letter. This was agreed as written evidence to be read by us.

v. Dr John Welch (Consultant Neuropsychologist) dated 30 June 2007, with one exhibited letter. This was agreed as written evidence to be read by us.

d. During the course of the hearing the Appellant produced and in the absence of objection from the PCT was allowed to put in a copy letter dated 9 August 2007 from Dr William F Cunningham, confirming that Dr Khadri had undertaken 6 observation sessions at his GP surgery in 2006 and a further 4 recently.

Background

15. Dr Khadri is a medical practitioner, born on 14 July 1943, as appears from the NCAS assessment, and is therefore aged 64. He had been practising as a GP in the Walker area of Newcastle upon Tyne for some 31 years, until his suspension by the PCT on 4 April 2005. It is said to be a deprived inner city area. It is a single handed practice and Dr Khadri's wife was his Practice Manager. There were other staff including receptionists and a practice nurse.

16. In January 2005 Dr Khadri fell ill and the PCT provided locum cover, and for the last two weeks of that month took over the day-to-day management of the practice. Concerns emerged about the practice. At the end of the month Dr Khadri resumed his practice. In March 2005 he fell ill again and the PCT again assumed responsibility for it, putting its own employee in as Practice Manager. She subsequently produced a report highlighting a range of concerns, both administrative and clinical, as a result of which Dr Khadri was notified and invited to attend a suspension hearing on 31 March 2005. He was suspended pending investigation of the concerns identified.

17. That suspension was extended on a number of occasions, without objection by Dr Khadri, until the decision which is subject to this appeal. In the result Dr Khadri has been out of clinical practice for almost 29 months by the date of this hearing.

18. Meanwhile the PCT took advice from the National Clinical Assessment Service (NCAS) but it was not until July 2006 that a formal agreement to assessment by the NCAS was signed by all parties. It is not suggested that Dr Khadri was other than co-operative and agreeable to investigation throughout all these processes.

19. The NCAS assessment comprised:

a. A behavioural assessment (performed on 1 September 2006);

b. A Clinical assessment (performed on 18-20 October 2006), and
c. A simulation of consultations with patients (17 October 2006).

A draft assessment report was provided to the PCT and to Dr Khadri on 4 December 2006, and the final version was issued on 10 January 2007. We were told and accepted that the difference between the two versions was simply that the comments provided by each party were annexed as parts F and G to the original report.

20. In light of that report the PCT wrote to Dr Khadri on 12 January 2007 informing him that it intended to review his suspension and was considering contingent removal or removal from the Performers List. 15 February was the date given for an oral hearing, but this was subsequently postponed to 15 March 2007.
21. Meanwhile (and pursuant to recommendations in the NCAS report) Dr Khadri underwent various other investigations:
    a. On 7 February 2007 he took and failed the Summative Assessment MCQ at the University of Newcastle Postgraduate Institute for Medicine and Dentistry. He obtained a score of 51.15% against a pass mark of 70% and a mean mark achieved by all 393 candidates of 77.68%. His was the lowest mark achieved in the country, among a failure rate of 6.9% [supplementary statement of Dr Harrison paragraph 3]. The MCQ assessment was the subject of a letter from Dr Harrison to the PCT (dated 19 February 2007, Case Papers page 65) in which he explained that the marking scheme did not include negative marking (deducting marks for wrong answers to the multiple choice questions), that there was variance on the scoring such that 4-5% around the pass mark reflected competency, and that in applying this assessment as a tool to assess trainability, any mark above 65% would have the possibility of reflecting competence. However for the purpose of assessing suitability for acceptance on the Deanery's retraining programme, 60% was taken as the required standard (for entry). A score significantly below 60% reflected a very significant gap in clinical knowledge. It was not possible to perform effectively without an adequate clinical knowledge base.
    b. He was seen by Dr Paterson (Occupational Health Consultant) on 27 February 2007. He reported that Dr Khadri has informed him he now had a prescription for reading glasses but these were not essential and he did not think eyesight was a significant factor in his current difficulties. He also reported he had been seen in the Audiology Department for some left sided hearing loss and had been referred for specialist appointment to see if there is any cause for this. However during his consultation there had been no problems with hearing and he therefore did not feel there was a significant hearing problem; see letter of 6th March Case Papers page A68. We should say that we do not have any information as to what the result of any specialist

audiology referral has been. In these circumstances we have to rely more than usually on our own observations during evidence.

c. He was examined by Dr Welch (Neuropsychologist) on 21 February 2007. His findings were originally set out in his letter dated 5th March 2007 and repeated in his witness statement. It is necessary to set these out in a little detail:

   i. Among other things, he found verbal IQ of 105, on the 63rd percentile, but by contrast his non-verbal abilities were lower at 91, which is still in the average range but on the 27th percentile. His full scale IQ was 99, functioning on the 47th percentile. This suggested, clinically, that there may be slight impairment with respect to non-verbal abilities and Dr Welch noted difficulties in relation to visual information processing speed and non-verbal reasoning which were sufficient to raise a question mark that there was some underlying cognitive problem.

   ii. Assessment of memory function was "slightly strange" in that his scores in relation to immediate recall suggested functioning at around the 37th percentile, while delayed memory was equivalent to functioning on the 88th percentile. This did not demonstrate rapid forgetting but did suggest concentration difficulties.

   iii. Overall, Dr Welch suggested that the assessment did not immediately suggest that Dr Khadri was suffering from a degenerative condition, but there were anomalies. In his opinion the assessment "does not provide the blanket reassurance that would be necessary to say that there are no problems in relation to cognitive functioning. I think it raises question marks, both in terms of the level of ability noted, his difficulty with certain types of reasoning, and the ease with which he became distracted and unable to function properly when anxiety levels were raised."

   iv. He suggested more comprehensive testing, particularly looking at anxiety levels and repeating some testing, and to re-assess Dr Khadri in 9 months time if it were decided he was fit to continue practising in the future.

   v. He concluded that these initial results were not such that he could immediately give him a clean bill of health, but equally, they were not so bad that he would suggest that he immediately stop practising. He was concerned that an explanation was found, and if that was merely a function of situational anxiety, to recognise that.

22. Following receipt of these investigations Dr Morris completed his Investigating Officer's report in which he recommended that in view of the large number of concerns now identified, and

taking into account patient safety and the needs of the service, it was not appropriate to remove Dr Khadri contingently, and that he should be removed from the List.

23. After the PCT's decision which is the subject of this appeal, Dr Khadri re-sat the Summative Assessment MCQ on 2 May 2007. He again came last in the country (supplementary statement of Dr Harrison para 4), this time with a marginally improved mark of 52.12%, where the pass mark was 67% and the mean mark achieved by the candidates was 75.53%, with a pass rate of 93.4 %.
24. Applying the criterion of 60% as a threshold requirement for retraining, the Northern Deanery did not go on to test clinical skills in simulated surgery. That test would also have to be passed, before a candidate is considered for the retraining scheme (Dr Harrison's letter page 66, last paragraph).

<u>The NCAS report and Dr Khadri's response to it</u>

25. In opening, Mr Post drew attention to some of the key elements of the NCAS report which were also highlighted in his skeleton. These included:
    a. Unsatisfactory practice had been identified in relation to 10 of the 12 simulated consultations in that test, including assessment of the patient's condition, investigation and/or diagnosis and clinical management [Case Papers A 32-33];
    b. Several of those examples concerned potentially serious conditions, eg examples 4,5, 6 and 7 on page 32 and examples 10,11, 14, 16, 18, 19 on page 33.
    c. There were multiple examples of poor prescribing practice [pages 37 and 38]. It was also noted that he was the highest prescriber of drugs with limited clinical value in this PCT.
    d. Dr Khadri's clinical record keeping was poor and crucially "*given the quality of the clinical records kept by Dr Khadri it would be difficult for another clinician to provide ongoing treatment to Dr Khadri's patients on the basis of their clinical record"* [pages 38-39].
    e. The Behavioural Assessment conclusions [page 57] were (final paragraph of that section) that while Dr Khadri's interview and psychometric profile suggested he was capable of change, the behavioural assessment suggested a combination of lack of capacity to be self-critical and a lack of insight into his shortcomings. He had a high degree of confidence in his own abilities, and tended to dismiss criticism. During the behavioural assessment he appeared not to be very interested in feedback. It was not clear to the NCAS assessors whether the assessment would stimulate him to a more critical stance about his own practice. It should be said that it was a major plank of Dr Khadri's case before us that he had now reflected on the criticisms, which he accepted, and recognised his shortcomings, and was keen to remedy them.

f. The NCAS proposed Dr Khadri undertake an *approved period of retraining*. It observed: [page 59] "*the [PCT] will need to take into account, as a priority, the safety of patients and the needs of the service.* It proposed that Dr Khadri be referred through Occupational Health services for neuropsychiatric assessment of his cognitive function, and so long as that suggested that he was capable of undertaking an educational programme, should be investigated by an audiologist to discover the extent of his presbyacusis, and should also visit the optometrist for a test of his visual acuity.

g. If Dr Khadri was fit to undertake an educational programme the PCT should approach the relevant Deanery to find out whether they were in a position to offer assistance. Dr Khadri would need a placement *within an accredited training practice* where he could undertake a period of *supervised practice* and address the areas for improvement [emphasis added]. If a placement within a training practice was not feasible, "alternative measures" should be considered.

h. Dr Khadri should work with an educational supervisor to devise and implement an action plan addressing the areas of concern in the NCAS report, and should also be offered a mentor to provide personal support.

26. Dr Khadri's witness statement and (in due course) oral evidence made clear that he now accepted the criticisms of his clinical skills set out in the NCAS report. He conceded that at the date of his assessment he lacked insight and was not self-critical. Having read and re-read the report he had reflected on the contents and told us that he acknowledged that his skills were not up to the required standard, and he needed to retrain to bring them back up to that standard. We must return to this topic later in this decision.

<u>Oral Evidence</u>

27. We heard evidence from Dr Morris and Dr Harrison on behalf of the PCT, and from Dr Khadri on his own behalf. It is not proposed to set this out in full.

28. Dr Morris drew attention to the NCAS report, and some of the particular clinical shortcomings flagged up by Mr Post in opening. Among the examples at section 4.1.1 of the NCAS report [Case papers page 29] he spoke about 5 examples. He explained that (for example) it was of real concern that Dr Khadri made no link between a patient's complaint of focal migraines and the fact that she was on the oral contraceptive. This and her complaint of dysphasia during migraine was essentially a contra-indication to the oral contraceptive because the patient was at high risk of stroke. It was also of concern that he told a patient that an ECG would exclude angina (which it cannot do) and that an inadequate history meant he was not in a position to make a correct diagnosis or give the correct treatment.

29. He also told us that support had been offered to Dr Khadri after the initial suspension hearing, offering help with continuing professional development (CPD) through a clinical tutor. It was

not taken up at that stage. He subsequently contacted Dr Khadri on about 3 occasions. On the first occasion he said Dr Khadri had not done anything (although he accepted this may have been an occasion when he had to go to India on account of bereavement), he had arranged a trainer and later found Dr Khadri had attended on only one occasion. The third occasion was shortly before the NCAS assessment when Dr Morris arranged for a trainer out of area in Corbridge (Dr Cunningham) and Dr Khadri in fact sat in with him on six occasions.

30. On receipt of the NCAS report he had been open-minded about the possibility of retraining but frankly found the prospect daunting because there was such a wide range of deficiencies over a large number of core clinical skills and knowledge, and he was doubtful that the intensive level of the retraining could be achievable. What caused a change of mind for him (he told Mr Davy in cross-examination) was the receipt of the Northern Deanery letter dated 19 February (Case Papers page 65-66), in which Dr Harrison set out the scores achieved in the MCQ and explained the matters set out at paragraph 21 (a) above. In his view the PCT could look to the Northern Deanery for expert advice on retraining. He also pointed out that this was a well-established tool as a way of assessing trainability of a doctor causing concern, and the threshold entry requirement of 60% was taken as allowing some scope for improvement during the programme (i.e. up to 70% pass mark as an exit requirement). Dr Harrison's letter had said "in our opinion it is not possible to retrain a doctor effectively without that level of existing knowledge". In summary the Northern Deanery would not offer Dr Khadri a position for retraining. This made the difference for Dr Morris. He could not longer imagine how conditions could be drawn which would remove the prejudice to the inefficiency identified in the assessments:

    "*It made it difficult to think of any way we could satisfy NCAS requirements. Without retraining he was not safe to return to practise*".

    The Northern Deanery would not offer retraining. The basis for their taking that decision was in itself one which reinforced the NCAS assessment as to the nature and degree of Dr Khadri's lack of basic core knowledge. No other accredited retraining scheme appeared to be available.

31. Since the suspension three significant prejudices to the PCT's patients and effective management had arisen, on Dr Morris's evidence. Firstly, the PCT had been continuing to remunerate Dr Khadri but had also paid for two locums to cover the practice (one full time equivalent). Therefore the PCT was paying twice for the provision of one full time doctor to this patient list. That was money which could otherwise be spent on patient care. There was in his view no reasonable prospect in the reasonably near future of that situation being brought to an end by successful retraining and resumption of practice by Dr Khadri. In cross examination he agreed that it had been the same two locums for the last year, but a locum did not have the financial incentive or commitment, and could at any stage leave to further his

career elsewhere. Secondly the patients were denied the certainty and comfort of a permanent settled GP with whom they could have the sort of doctor/ patient relationship patients wished to have. Thirdly unless and until there was a decision about removing Dr Khadri from the List, the PCT could not undertake any consultation with the patients on his List, as they were obliged to do, before deciding what to do about his replacement.

32. Dr Morris agreed with Mr Davy that Dr Khadri had consented to all applications to extend his suspension, had agreed to the NCAS assessment, had accepted its result, had complied with the recommendations to undergo occupational health assessment, neuropsychological assessment and hearing and optical assessment. He had also complied with the Northern Deanery's requirements to undergo a Summative MCQ assessment. It was put to him (and he did not dissent) that there were three hurdles involved in the NCAS recommendations:
    a. a report from a neuropsychiatric assessment;
    b. reports from an audiologist and optometrist;
    c. an educational programme in which the Deanery was to consider placement within an accredited training practice or if not feasible, to consider other measures.

    It was envisaged that if the training programme was satisfactorily completed he could return to practice. Dr Morris pointed out that if Dr Khadri had passed the 60% hurdle used as the minimum Deanery criteria for basic core medical knowledge, that did not in itself make Dr Khadri suitable for training; simulated surgery was also assessed, and it would still have been appropriate, had he been accepted for retraining, to consider contingent removal.
33. He was asked if there was anything the PCT could do to help bring Dr Khadri up to the MCQ 60% standard. He said the PCT did not have the facility or resources to get basic medical education up to scratch. In his view this was knowledge at a basic level for doctors: "it is about going back to medical school or working as a junior hospital doctor. I would say I don't think we could be responsible for organising retraining in that matter". There was a distinction between organising observation sessions of the kind Dr Khadri had now arranged with Dr Cunningham, and what the NCAS report had in mind. There were a very large number of hurdles to be overcome before he could either get accepted for appropriate training or satisfactorily complete it. NCAS report identified a large number of failings, over a wide range of GP competencies, and some of those were potentially significant failings. There were also concerns about whether he had sufficient insight to be able to deal with these things. It was put to him that despite all that the NCAS had recommended he should undergo retraining to try to address them. Dr Morris came back to the fact that the recommendation was conditional on success in surmounting the preliminary hurdles, and it appeared in the light of the Northern Deanery findings and the (now) two failures in the MCQ when there had been a significant shortfall below the minimum requirement, that it was regrettably unlikely that Dr Khadri could ever satisfy the entry requirements for a suitable retraining.

34. Dr Morris appeared taken aback by a suggestion on behalf of Dr Khadri that the GP contract could in some fashion be transferred to one of the two locums (a Dr Thick was suggested) with the agreement of Dr Khadri. It was not an arrangement with which he was familiar, or thought possible without legal contractual problems and in any event he was not personally in a position to offer a view. However the ideal situation for this practice was undoubtedly to have permanent staff.
35. Asked by the Panel about the involvement he had expected from the PCT in the event that training proceeded, he said he thought there would have been discussions with the Deanery and Dr Khadri to secure tailoring of the retraining to address the concerns identified by the NCAS. He confirmed that the shift in attitude by the PCT was as a result of receiving the Northern Deanery report rejecting Dr Khadri for retraining. He was asked about appraisals of Dr Khadri's practice and said that from memory there had been a satisfactory appraisal report in 2004, but appraisal now was a much more robust process than it had been then. Asked about site visits pursuant to the new GP contract, he said that (again from memory) Dr Khadri had been in the bottom three practices in Newcastle.
36. In re-examination Dr Morris said that the NCAS assessment does not contain any equivalent of the MCQ basic medicine test. They were devised for different purposes and the MCQ made the picture infinitely worse: "it was the level of a medical student or new doctor in training". Dr Morris could not be confident that Dr Khadri's performance in simulated surgery would have been any more satisfactory than the MCQ test, since the NCAS assessment had included such an element and this had given rise to grave concerns.
37. A question was raised about documents relating to site visits but after conferring overnight the parties took the view they were not relevant and declined to submit any further evidence on this point.
38. We considered Dr Morris to be a careful and fair-minded witness, whose views were rationally supported. It was clear that he took his duty to ensure patient safety and quality of healthcare as the paramount concern, but was mindful of the impact of this decision on a GP who had practised locally for 31 years as a single handed practitioner. In our view he did not reject the realistic possibility of retraining Dr Khadri lightly, but after weighing all the difficulties and taking what he genuinely believed to be a realistic view of the likelihood of Dr Khadri successfully retraining within a reasonable time frame. Whether we ultimately agree with him or not, we accept that his recommendation to the PCT was based upon a reasoned and genuine belief that it was not practicable to devise conditions which would be likely to remove the prejudice to the efficiency of the services which had been identified.
39. Dr Harrison gave evidence. He has no connection with the PCT, other than to receive requests to consider retraining. We considered him to be an impressive witness, who showed a command of the education and training offered by his own Deanery and others, and (as a

GP who continued to practise himself) a keen awareness of what was and was not necessary for effective clinical performance, and of the limitations of what a working GP could offer by way of supervision of a colleague who required retraining. He was able to offer telling examples of his general propositions, but was also careful to say when the limits of his own expertise and experience had been reached. He took time to reflect before answering where appropriate, and had a refreshing dash of candour and realism. We have no hesitation in accepting his evidence.

40. He was asked to amplify the content of his letter to the PCT of 19 February 2007. Some of that information is set out above. He explained that the MCQ assessments had been subject to challenge and had been validated as a fair and effective tool to measure working clinical knowledge. They contain three elements: clinical management, practice management and how the NHS is involved. It is practical and relevant to GP practice. Most candidates are doctors going through GP training within 5 – 10 years of qualification, others come from other specialties, and yet others are returning after career interruptions. Because there is no negative marking, you can make an informed guess at the answer and it is often the case that these are accurate. The knowledge required is core knowledge. The gap between Dr Khadri and the pass mark indicated a significant deficiency in his performance. If a doctor passed that and the other entry requirements, he would be placed in one of a number of advanced practices where there GP trainers, over a period of 6 months, which might be extended to 12 in some cases. The doctor will then see patients in consultation and these patients are reviewed by the supervisor but not necessarily at the same time as the trainee sees them. It was important that the programme was properly supported and the person entering is suitable for retraining. The Deanery's retraining schemes or returners scheme assumed a basic level of knowledge and skill. The way into the programme may differ for returners and retrainers, but the standard aimed at within the programme was the same. Dr Harrison said, when asked about the significance of the low score:

    "He would not be fit because he would put patients at risk. Also the Deanery is not in a position to provide that basic knowledge. There is also an issue as to efficiency because we could not deliver the degree of supervision necessary for this level of retraining. The financial cost would be high and it would not be possible – a GP trainer would not be willing and their practices would not be able to run [given the amount of supervision required]. Every patient would have to be checked in real time and that would be impractical."

    He explained that there was also a likelihood that even if a trainer were willing in principle, it was unlikely that his partners would find this commitment acceptable, and there was an issue about patient consent to being seen by Dr Khadri, given that the level of his deficiencies would put patients at risk: what should such patients be told before being seen?

41. Asked about the 3 – 4 hours daily study time which Dr Khadri had told the NCAS assessors he was doing whilst suspended, Dr Harrison said he would expect that to demonstrate a big benefit, contrary to what was actually achieved on the MCQ.
42. Dr Harrison thought that whilst he could see an argument that on the first occasion when Dr Khadri took the MCQ test, unfamiliarity with a style of test he would not have taken before might have affected his mark, the same could not be said of the second test. By then he knew the style of question and had had several weeks to prepare himself. A second test usually produces an improvement. He was asked about the small percentage improvement between the first and second tests. He said he was not a statistician but felt there was not a huge difference. Both suggested Dr Khadri had a significant deficiency in his basic knowledge. Not only would he need to get up from around 52% to 60% to achieve the entry threshold, a jump which experience suggested was a very big undertaking, but he then needed to improve by a further 10% to obtain the pass mark of 70% by the end of 6 months retraining or such longer period as was allowed. He felt it was a huge gamble and was not persuaded that Dr Khadri had demonstrated the capacity to learn and apply his knowledge. Without the capacity to learn and apply, retraining was not going to be effective.
43. Places on retraining courses were a scarce resource and had to be allocated fairly, equitably and with a view to a return. In general, although some Deaneries had abandoned providing such courses, the Northern Deanery had considered that they provided a good return on investment. This review had been performed because funding to the Deaneries had become cash limited, and they had to be satisfied that it was an efficient use of the overall budget.
44. While it was not strictly enforceable, it was expected of candidates who were accepted for retraining that they would practise in the NHS for at least 2 years after completion of training.
45. Shown the NCAS report by Mr Davy, Dr Harrison said that the simulated surgery exercise carried out by the Deanery would cover some of the same ground as the one done by NCAS. However their purposes were different. He was very concerned by the content of the NCAS report, which raised concerns over a large range of competencies and those deficiencies arose unpredictably. It was difficult to know what Dr Khadri did not know. He likened it to trying to improve a football team where all the players have deficient skills of unknown extent. Performance depended on knowledge, level of competency and skills and performance, and the ability to learn. These documents and the two successive MCQ tests raised a question about his ability to learn. The low MCQ scores showed he posed a significant risk to patients, and the Deanery's processes would not address that basic gap in knowledge. The low scores also suggested that training is unlikely to be effective: "the ability to gain knowledge is difficult, we are not doing it. It comes out of your basic training and your experience as a doctor. Moving from there to a satisfactory level is very difficult and probably impossible".

46. Asked about the processes used in retraining, Dr Harrison said that “the best way to learn is by doing, but that depends on seeing patients and you are precluded here. There is a limit to what you can learn on the internet if it is not practice based.” He knew Dr Cunningham but doubted if being an observer only was going to remedy the defects. He said “I think it becomes stale after a number of weeks. It is like watching someone play golf, as opposed to actually hitting the ball in practice”. He was asked if he would agree that attending Dr Cunningham’s practice as an observer and remaining dedicated through self-lead training would provide a reasonable prospect of improving his MCQ score to within 10%. He replied “I would not believe so, no”.
47. On another practical issue Dr Harrison said that the Deanery would provide funding under a Returner Scheme (a doctor out of practice in excess of 2 years) but not necessarily a Retraining Scheme. This might be met by a mix of funding from the Deanery, the PCT and the practitioner in whatever proportions were agreed. The cost could be £50,000 which equates to the cost of a locum (i.e. to assist the practice of the trainer who was devoting time to the trainee). Asked about whether the cost might be less, he said “It will be at least £10,000 for 3 months and at least 2 or 3 times that for 6 months if you can get the people – people are not looking for this kind of work”. As to the period of training to get up to the entry level of 60%, there would be no funding for that and it would have to be met by the GP himself.
48. Questioned by the Panel Dr Harrison reiterated that this was a well established and fair test of practical knowledge. What troubled him was the lack of consistency in Dr Khadri’s knowledge and Dr Harrison felt it was difficult to know all the areas where he had weakness. He would hate to say any doctor was a lost cause or completely untrainable but the difficulty was how would they do it, was it do-able, and what amount of resources would be required? He also thought there was no evidence that any insight he claimed to have developed had been translated into his learning.
49. He said that if Dr Khadri had passed the entry tests he would have met with Dr Morris and the proposed trainer and Dr Khadri to hammer out where they went next. A trainer would find it difficult to accommodate these problems. The Deanery could not dictate to a GP trainer or require him to take on this GP. It was regrettably the case that “it is unfeasible to approach retraining”. If the Deanery offered a package it had to be achievable. He could not reconsider the decision not to offer retraining as a result of what he had heard and read in this hearing. In fact the NCAS report reinforced his decision.
50. Dr Khadri gave evidence. He appeared to us to have substantial difficulty in following or answering relatively straightforward questions. His witness seat was located within a few feet of Counsel on one side and the Panel on the other. As a matter of impression it seemed he may be hard of hearing but we have neither seen nor carried out an audiological evaluation.

Another possibility canvassed in the papers was cognitive impairment, and the factors described by Mr Welch might account for some of the tendency to answer a different question from the one put, or to seek assistance from the Panel before answering. We are not in a position to say what is the explanation, but there clearly is something which makes communication slow and difficult.

51. He described his practice as a single handed one with 2,250 patients on his list. He was taken to the NCAS assessment and said "I accept those conclusions and the recommendation in the report". He said at the time of the assessment he had no insight into his problems, but after going through it a number of time he realised he had quite a number of points to address. He now accepted he had areas of significant clinical deficiencies.
52. When he was later taken to a number of areas of the assessment report, there appeared to be a mismatch between this acceptance of deficiencies and the excuses he made about particular deficiencies identified by NCAS. Asked about the record keeping he said that the records selected by the assessment team were ones which had been compiled by locums and although he accepted he had the responsibility as Principal, the failure to make adequate records was that of these locums. He said "I am saying that my own record keeping was satisfactory". He acknowledged that the 13 patient records selected by the assessors were at random. He was willing to say that the other 2,237 patient records would mostly have been fine.
53. Asked about the NCAS simulated surgery in which he had shown defective skills in relation to 10 out of 12 patients, he said that he found it difficult because the actors did not behave like real patients. He found it difficult to read their body language and facial expressions which did not match with the information being given. He did not think they were very good: they appeared to mix up the history they were supposed to give in their role as patient with their own personal history.
54. Asked about his performance in the MCQ tests he said the first occasion was his first experience of this kind of test, and during the second test he had been suffering left sided sciatica, which made it difficult to concentrate. He was sure that in 6 months time he would be able to achieve 60%. It was pointed out to Dr Khadri that although his witness statement refers to sciatica it is for the purpose of explaining his failure to make enquiries about possible training courses from May until the end of June. It is not suggested in that statement that his performance in the second MCQ was impaired by sciatica. As we were not shown any medical evidence certificates relating to sciatica, it is not possible to find corroboration for when the condition started.
55. Dr Khadri also suggested that the MCQ test was itself favourable to other candidates who had done their training recently in hospitals, tailored to their becoming a GP. They attended GP lectures and were well prepared for the MCQ.

56. Dr Khadri repeated on a number of occasions that he felt he could get up to 60% on the MCQ or its new equivalent, with self-guided study, and was willing to fund it himself. He was very keen, he said, to remedy his deficiencies and follow the recommendations of NCAS so that he could resume his practice which had been his life, and serve his patients.
57. What he had done so far was to read and do on-line learning at home, to re-sit the MCQ (unsuccessfully) and arrange further observation sessions with Dr Cunningham in his practice (limited to 4 to date, starting in July). Most courses only started this September. He had exhibited to his statement some which were available: these were CPD courses addressing discrete areas of practice, often with an updating flavour. After his disappointment with the Northern Deanery he had not approached any others, because he understood that they would all operate a similar entry requirement to the Northern Deanery. However over the Bank Holiday weekend in the middle of this hearing he had tried to contact a Deanery in the North of Scotland because he understood the Scottish and Welsh Deaneries might not operate the same entry requirements. Unsurprisingly, he was not able to obtain any substantive reply or information by the time the hearing resumed on Tuesday 28th August. He agreed with Mr Post that he had had 5 months since the PCT's decision to remove him, and was effectively no further forward in getting a training place.
58. Asked how long he intended to practise if he were able to resume, he said as long as he remained physically fit. If her were removed from the list he would be out of his profession which he would find very upsetting. It would also cause financial hardship because he had a substantial mortgage taken out 5 years ago, for house improvements, and had been supporting his son through medical school and paying his mortgage. He had, however, been receiving a salary during his suspension. He said this was about 10% less than what he earned before suspension and this in itself caused hardship. At first he mentioned £100,000. Then he said he had been receiving £73,000 gross, before suspension, and it was now about £65,000. Taxed about this later by the Panel, it transpired that he did not mean this was his gross practice income, but that it was the net or taxable figure after expenses. Those expenses would include the cost of his wife as Practice Manager.
59. Asked about how long he felt the process of retraining would take him, he said he thought the entire process could be completed in 6 – 9 months. Later in his answer he seemed to accept that the whole process might take a couple of years. The suggestion of 6 – 9 months was not adopted by Mr Davy in closing submissions. He adopted the period of 2 years or so.
60. We have considered with care the closing submissions made in writing on behalf of the parties and amplified in oral argument. It is not necessary to set them all out here. Mr Post argued that applying the test under Regulation 12 we should consider whether there a realistic likelihood of being able to remove the prejudice to the efficiency of the services within a reasonable time frame, whether by imposing the conditions suggested on behalf of Dr

Khadri, or any others. He submitted that the answer was in the negative. There was no point in imposing conditions that would offer no real prospect of Dr Khadri returning to practice in the foreseeable future, particularly as meanwhile the PCT and the patient population would suffer the threefold serious disadvantage identified by Dr Morris (see above). In oral argument he further submitted that the conditions proposed (and indeed any conditions likely to be devised in these uncertain circumstances) lacked certainty and could not sensibly be policed, since the PCT would not be able to say when a "reasonable" time had elapsed for completing the retraining, and Dr Khadri was only being required to undergo a further neuropsychological assessment, but the conditions did not cater for the situation if he "failed" that assessment or it identified more serious problems. In the particular circumstances of this case he relied (among other things) upon:

a. the significant deficiencies over a wide range of core clinical competencies demonstrated by the NCAS assessment, as a result of which Dr Khadri was not safe to treat patients and indeed accepted he fell short of the standard required of a GP;
b. the refusal of the Northern Deanery to offer him a re-training place, applying to Dr Khadri the same entry test they did for other candidates seeking a scarce resource;
c. the profound lack of basic core medical knowledge demonstrated by the two failures at Summative MCQ Assessment;
d. the failure to achieve anything more than a marginal improvement on the second occasion despite devoting a lot of time to self-guided learning which busy practising doctors would be unable to afford;
e. the lack of any adequate evidence of a capacity to learn and improve even to the level of 60% on the MCQ, still less the further 10% to achieve sufficient competence to complete retraining satisfactorily;
f. the lack of insight demonstrated, on examination of his responses to questions about the NCAS assessment.

61. Mr Davy focused on the three hurdles about which he had cross-examined, and submitted that we only had to consider the prospects for Dr Khadri being able to achieve the entry level score of 60% on the MCQ test or its equivalent within a reasonable period of time. It could then be assumed that he should be capable of getting up to 70% exit requirement, as Dr Harrison had stated that a doctor who achieves the entry requirement is retrainable and the Deanery has assessed the retraining scheme as a cost effective and efficient use of resources if the doctor can satisfy the entry requirements. He pointed to various factors (paragraph 25 of his submissions) which he suggested should enable us to be satisfied that a reasonable period of time to get up to 60% was 6 – 9 months and that a further period of 6 to 12 months in training was likely. On the issue of the prospects of Dr Khadri in fact achieving the 60% entry requirement in that period, he invited us to consider his motivation and his

aptitude for learning, and set out various factors on the issue of motivation (paragraph 30) and aptitude (paragraph 31). On the latter issue he developed an ingenious argument to the effect that the score on the second MCQ test was actually less than 5% from the threshold. This involved him redefining the threshold in a way which contradicted the evidence of Dr Harrison that 60% was a rule of thumb, intended to be generous to the candidate, and was used as the entry requirement in fact. We reject the approach Mr Davy invited us to take on this issue, as unrealistic and wrong.

62. Mr Davy submitted we should look at his prospects of passing the entry requirements as an exercise in balancing factors and acting fairly and reasonably. He pointed to the hardship which was likely to follow removal from the list and the detriment of effectively ending a long medical career. Against this there would be benefits to the services in producing a retrained Dr Khadri, able to resume patient care and draw in his long experience.
63. He submitted that the following slightly revised conditions should be adopted:
    a. Undergo a further assessment by a neuropsychologist;
    b. Successfully complete the Deanery's entry requirements for any retraining scheme within 9 months;
    c. Thereafter, within a reasonable period of time complete a retraining scheme and successfully comply with any exit requirements from that scheme imposed by the Deanery.
64. We accept that in considering whether to remove contingently or outright, we should consider Regulation 12 of the 2004 Regulations and in particular whether the PCT has satisfied us that it would not be fair and appropriate to impose conditions with a view to removing the prejudice to the efficiency of the services which has been identified.
65. We have considered the level and nature of the deficiencies which have to be remedied before Dr Khadri could return to practice, consistent with the requirements for efficiency, chief among which is patient safety. We accept the view of Dr Morris and supported by Dr Harrison that these were significant deficiencies, over a wide range of core clinical competencies, complicated by the fact that the areas of poor performance were unpredictable and it was difficult to know where his core knowledge began and ended. There were examples of failings which were serious in the NCAS report. We also accept that the exceptionally low MCQ scores showed a want of basic core medical knowledge and that Dr Khadri posed a significant risk to patients. The Deanery's processes would not address that basic gap in knowledge. The low scores also suggested that training is unlikely to be effective: as Dr Harrison said "Moving from there to a satisfactory level is very difficult and probably impossible". Identifying the level of deficiency is a necessary staring point in our view, not least because as Dr Harrison said, "getting from 52 % to 70% is a huge jump". Realistically

he could not consider it. We refer to the evidence given by Dr Harrison as summarised above.

66. We note that Dr Khadri himself accepts that his clinical skills fall below those required of a GP in practice and that he requires retraining to recover an appropriate level of competence.
67. In considering next whether Dr Khadri is likely to achieve the 60% entry requirement to a Deanery sponsored retraining course (no other type of retraining being suggested on behalf of Dr Khadri) we take into account the starting point set out at paragraph 65 above, and (as Mr Davy invites us to do) Dr Khadri's motivation and aptitude. While he professes motivation, Dr Khadri has made little or no progress in the 8 months since he received the NCAS report as a result of which he says he realised his shortcomings. He has advanced a variety of excuses as to why he has been unable to investigate and join courses, but says he has been doing 3 – 4 hours a day, 5 days a week of self-guided learning on the internet and reading, despite which he has achieved the worst score in the country in the MCQ on two occasions. Strikingly, he only got round to investigating an alternative Deanery retraining in the middle of this hearing. His recommencement of observation sessions with Dr Cunningham was only in July (around the time this case was originally listed).
68. Similarly the best that can be said about his aptitude is that he made a marginal improvement between the first and second MCQ tests, but on both occasions was the lowest score in the country and was far enough off even a retraining entry requirement to be reckoned to be unsuitable, for lack of basic medical core skills, which a Deanery retraining course was not intended to supply. These are woeful scores and in our view, supported by our impression of Dr Khadri in the course of his own evidence, he lacks aptitude to improve to the required entry level for a retraining course. This does not mean he will be incapable of any improvement at all, but he will not be capable of sufficient improvement or in any sort of reasonable time frame. Nor are we satisfied on the evidence that there are courses which are designed to achieve this kind of basic remedial teaching, or that Dr Khadri is able to identify them. Self-guided learning has not been effective to date and there is no reason to suppose it will be in the future. Considering the neuropsychology assessment in this context, and in particular the findings on IQ testing, does nothing to contradict the proposition that Dr Khadri lacks appropriate aptitude.
69. We also take into account Dr Khadri's insight in assessing the likelihood of achieving entry to a retraining course. In our view he lacks real insight, notwithstanding his assertion that he accepts his deficiencies. We refer to his evidence summarised at paragraphs 52 to 55 above, and accept the submissions of Mr Post that these and other matters do not demonstrate that he has in truth accepted the NCAS report or that he has insight. When pressed, these deficiencies are failings by some other person, or are someone else's fault, or are due to matters beyond his control. The points about the clinical records and about the deficiencies of

the surgery simulations are profoundly serious criticisms of the competence of the procedures adopted by NCAS. It is inconceivable that if that was the case Dr Khadri would not have raised those points in response to the draft report, assisted as he was at the time by a medico-legal adviser. Examination of the comments made on his behalf in the report show he did not make these points at the time. In our view he simply does not find it easy or possible to acknowledge that the fault lies with no-one but himself. These findings are more consistent with the concerns expressed in the NCAS report about his lack of insight, than they are with his professed conversion to insight and self-criticism.

70. We accept Dr Harrison's view about the prospects for retraining and are satisfied that there is no realistic prospect of Dr Khadri either securing an accredited training place with a Deanery, or satisfactorily completing any training. We do not accept the approach argued by Mr Davy that we only need to concern ourselves with the prospects for getting onto a course, because we find it to be artificial and unrealistic to pay no regard to the chances of his improving yet further to the exit requirements of 70%. However, in case this is wrong we have looked at that limited question in isolation and in our view there is no realistic prospect of Dr Khadri satisfying the entry requirements for a Deanery course of 60% on the MCQ or equivalent, whether in a reasonable time or at all.
71. We also find that it is highly unlikely that a retraining programme could be offered to this particular doctor in light of his intensive requirement for supervision. This would place a burden on a prospective trainer which would be unrealistic and impractical. Dr Khadri referred in his evidence to being happy to conduct consultations with a GP trainer "looking over his shoulder". That just could not happen without disrupting the training practice to an unacceptable degree. It is in our view unlikely that any GP trainer could be found to offer this doctor the intensive supervision required, or that it would be acceptable to his partners, or to the patients. Nor should the NHS be expected to provide such supervision which arises from a lack of basic medical knowledge which the doctor should know from medical school days.
72. The prejudice to the efficiency of the services flowing from Dr Khadri's clinical deficiencies include the substantial risks to patient safety (examples of which are given above) and incidental increased prescribing costs. It includes the extra costs of providing locum cover, and the other detriments identified by Dr Morris, namely the loss to the patient of a relationship with a permanent GP and the inability of the PCT to embark on a consultation about the future of the practice. It includes the cost and intensive use of resources which would arise from offering him retraining.
73. In view of our conclusions at paragraph 70, it would be useless to impose conditions of the kind suggested, with a view to removing the prejudice to efficiency of the services.
74. In any event we consider the conditions proposed to be unrealistic, not sufficiently certain and not reasonably capable of being policed. We do not accept that 9 months will see this doctor

achieving entry level scores on the MCQ or equivalent. What is a reasonable time is bound to be a contentious issue between the parties. Moreover there is only a requirement to undergo neuropsychological assessment, and no provision for what is to happen if it throws up serious concerns. Mr Davy suggested in argument that while he accepted this would not amount to a breach of the conditions, the PCT could start a new and separate process to remove him. This is a completely unrealistic proposition which we are unable to accept.

75. Against this we are urged to consider the financial impact on Dr Khadri. We do so, in the context of reminding ourselves that removal from the NHS Performers List is a serious step with a significant impact on the finances of the doctor. In itself, it does not prevent him from practising medicine or retraining, but realistically this doctor has spent his entire working life in the NHS. Our overriding concern is patient safety. We consider that balancing all the factors which have been urged upon us, the conclusion which cannot be avoided is that there would be significant prejudice to the services provided by the PCT if Dr Khadri was to remain on the Performers List.
76. We have asked ourselves whether there is a realistic possibility of curing this by imposing conditions, so as to enable us to remove him contingently as we are asked to do. We have reached the conclusion that we cannot adopt that course. We therefore reject the appeal and direct Dr Khadri's removal from the Performers List.
77. We have not been asked to consider National Disqualification and in the exercise of our discretion we do not do so.
78. In accordance with Rule 42 (5) of the Rules we hereby notify the parties that either party to these proceedings can appeal this decision under Section 11 Tribunals & Inquiries Act 1992 by lodging notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the date of this decision. Under Rule 43 of the 2001 Rules a party may also apply for review or variation of this decision no later than 14 days after the date on which this decision is sent.

1 September 2007

Duncan Pratt
Duncan Pratt
Chairman of the Panel