Case No.14526

THE FAMILY HEALTH SERVICE APPEALS AUTHORITY

Mr D Pratt – Chair
Dr M Sheldon – Professional Member
Mrs L Bromley – Member

Hearing: 27 August 2008

BETWEEN:

DR WOLFGANG REITER
(GMC registration number 4157494)

Appellant

-and-

WOLVERHAMPTON CITY NHS PRIMARY CARE TRUST

Respondent

DECISION AND REASONS

THE APPEAL

1. This is an appeal by Dr Wolfgang Reiter ("Dr Reiter") against a decision by Wolverhampton City NHS Primary Care Trust ("the PCT") to remove him from its Performers List under Regulations 10 (3) and 10 (4) (a) of the National Health Service (Performers Lists) Regulations 2004, as amended ("the Regulations") on the basis 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" ("an efficiency case").
2. The decision by the PCT followed a hearing on 24 April 2008 and was communicated by its letter dated 30 April 2008, which also enclosed a record of the hearing before the PCT panel. Dr Reiter did not attend that hearing, although properly notified of it, and of the possibility that he may be removed from the Performers' List. He did however submit extensive written submissions (which are also in the bundle of documents before us).

DECISION

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

REASONS

Preliminary matters

4. Attendance and representation. Dr Reiter did not appear at the hearing of this appeal. It was listed for 10.00 am. We adjourned the start of the hearing until shortly after 10.20, lest he had been delayed. By a letter dated 11 August he had informed the FHSAA that he would not attend the hearing. No further message was received on the date of the hearing, either at the hearing venue or at the offices of the FHSAA. Dr Reiter did however submit a number of documents and written arguments in addition to his Grounds of Appeal. We considered whether to proceed to a determination of the appeal in his absence, applying Rule 40 (1) of the Family Health Service Appeal Authority (Procedure) Rules 2001 ("the Rules"). We were satisfied from the extensive correspondence available to us that Dr Reiter had effective notice of the date, time and venue of this appeal hearing. Dr Reiter has not advanced any excuse, still less a reasonable excuse, for his non-attendance. We therefore determined to proceed to a hearing of the appeal.
5. The PCT was represented by Mr Paul Ozin, of Counsel, instructed by Mills and Reeve, solicitors.

6. Public or private hearing. We next addressed Dr Reiter's written request that he did not wish the hearing to take place in public for reasons of confidentiality. We considered Rule 39 of the Rules which directs that we *shall* conduct the hearing in public unless we make a direction otherwise under Rule 41 (4) which empowers us to direct that the hearing (or some part thereof) should be heard in private, if in our opinion it is *strictly necessary*. Dr Reiter's desire to have the hearing in private (coupled with his assertion that this Panel was not a Court) did not provide a basis for us to conclude that a private hearing was strictly necessary, so as to displace the obligation otherwise placed on us by statute to conduct the hearing in public. We considered the case at large, including whether there was evidence which was likely to concern matters of personal health or issues likely to cause harm to any person by being heard in public and could identify none. We therefore directed that the appeal should be heard in public.
7. Submission of late evidence. On 22 August 2008 the PCT's solicitors submitted a further document, namely Dr Reiter's application for inclusion on the medical Performers' List (being a document which is referred to elsewhere in the evidence). However the document itself had not been placed before the PCT panel which took the decision to remove Dr Reiter, and having considered our preliminary views on the effect of Rule 41 (7) of the Rules, and on the fact that Dr Reiter was not here to express his view as to whether we should receive it, the PCT did not pursue an application for us to receive and consider this document. In the result we removed and disregarded the application document, which had been provisionally paginated 127 to 142 of the Respondent's bundle.
8. Dr Reiter made a late submission of evidence by his letter dated 12 August 2008, and having considered our powers under Rule 41(7) we exercised our discretion in favour of admitting these documents, which were numbered A20 to A33. They included a copy of the personal development plan and the front and back page of Form 4 (Summary of Appraisal Discussion) which had been typed following Dr Reiter's appraisal by Dr Sharma.

Relevant legal framework

9. This appeal is brought pursuant to Section 49M of the National Health Service Act 1977, as amended ("the 1977 Act") and regulation 15 of the Regulations, by virtue of which it proceeds by way of a redetermination of the PCT's decision, and this Panel may make any decision which the Primary Care Trust could have made.
10. In our view the burden of satisfying us that the case is proved, lies on the PCT, and we invited the PCT to open its case, with oral evidence from its witnesses, and oral submissions thereafter.
11. Regulation 11 of the Regulations sets out the criteria for removal in cases of unsuitability and efficiency, and we have had regard to those and to the Department of Health Guidance, while not limiting our consideration of factors to those mentioned in the guidance, and we have considered all the factors urged on us in this appeal.
12. Regulation 12 gives us a discretion to remove Dr Reiter contingently from the Performers List, subjecting him to conditions, since the PCT has limited its case for removal to the ground of "efficiency". Contingent removal requires that we impose such conditions as we may decide with a view to "removing any prejudice to the efficiency of the services in question": regulation 12 (2) (a).
13. The standard of proof which we have applied is the balance of probabilities: whether a fact or allegation is more likely than not to have occurred. Mr Ozin submitted that in light of the decision of the House of Lords in *Re D* [2008] UKHL 33 we need not refine that test any further. However the panel recognises that some events are inherently more likely than others. When considering whether we are satisfied on a balance of probabilities that an allegation is established, we bear in mind that the more serious the allegation, the less likely it is that it occurred and the more persuasive should be the evidence before we conclude that the allegation is established. We have also had regard to the guidance given to FHSAA Panels by Holman J in *R (on the application of Dr Harish Doshi) v Southend on Sea PCT* [2007] EWHC 1361 Administrative Court in particular as to the practical application of a flexible approach to the civil standard.

Documents

14. The documents available to us were:

(a) an Appellant's bundle [identified as A 1 – A 33], which included:
Dr Reiter's grounds of appeal,
a copy of his submissions to the PCT at its original hearing,
copy email correspondence with the PCT,
further written submissions by letter dated 12 August 2008 with enclosures, namely
an undated copy personal development plan,
two pages of a Form 4 used during appraisals,
copy printed notes concerning appraisals,
a letter to Dr Reiter from his MDU adviser dated 16 July 2007, and
two documents relating to the formal investigation process by the PCT.

(b) a Respondent's bundle [identified as R 1 – R 126], which included (among other things set out in the index to that bundle):
The PCT's statement of the grounds on which it opposes the appeal,
The PCT's statement of facts
The Investigating Officer's report to the PCT and appendices
Correspondence with Dr Reiter, and
Minutes of the Professional List Panel Hearing (24 April 2008) and the decision letter under appeal.

<u>Oral evidence</u>

15. We heard evidence from the following witness called on behalf of the PCT:
    (a) Ms Wendy Ashford
    (b) Dr Satya Sharma
    (c) Dr Amjad Khan
    (d) Ms Lynne Allen

Dr Reiter did not attend and no oral evidence was called on his behalf.

<u>Background and issues</u>

16. We find that the background giving rise to this appeal is as follows.
17. Dr Reiter was admitted to the PCT's medical Performers List on 25 January 2007. Before the PCT panel it was alleged (and not challenged by Dr Reiter) that in so doing he was required to declare that that he would cooperate with the appraisal procedure in place at the PCT. Irrespective of that undertaking, Regulation 9 (7) of the Regulations requires that:

    "A performer who is included in a performers list of a Primary Care Trust shall, except where the relevant Part provides to the contrary –
    (a) participate in the appraisal system provided by a Primary Care Trust…"

    Dr Reiter was therefore under a statutory obligation to participate in the appraisal system, as were all others on the List, irrespective of whether they qualified in England or elsewhere.
18. The PCT had no information at that stage as to whether Dr Reiter had previously, or recently undergone appraisal, and so an administrator telephoned him to enquire and request that he had an appraisal if he had not previously done so elsewhere. That administrator and subsequently the lead GP for appraisal, Dr Khan, were taken aback by Dr Reiter's attitude and manner, which was said to be uncooperative in the extreme, and personally very difficult. He expressed the view that subjecting him to an appraisal would infringe his constitutional rights. He informed Dr Khan that because he was from (i.e. qualified in) the European Union, UK regulations requiring appraisal did not apply to him.
19. Ultimately, but reluctantly, he agreed to be appraised. The PCT asked Dr Sharma to appraise him. Dr Sharma offered Dr Reiter a preliminary discussion session to explain the process and what Dr Reiter would be expected to be able to explain and the information which would be required. Neither that session nor the substantive appraisal were happy events. Dr Sharma had never experienced an attitude towards appraisal like that of Dr Reiter. He refused to answer many of his questions, or to volunteer information, in particular as to his health and current Hepatitis B immunisation status, and talked about irrelevancies such as that people who administered the appraisal system were "pawns of the government, paid by Blair, and should be ashamed". Dr Sharma's gave a witness statement in which (we paraphrase) he recounts a failure by Dr Reiter to engage with the process in any way which was meaningful or useful, and was offensive and belittled Dr Sharma.

20. At the conclusion of an appraisal interview the appraiser must complete a form called Form 4, which on its final page invites the appraisee to sign his or her agreement that the account is an accurate summary of the appraisal discussion and agreed action and the agreed personal development plan. Dr Reiter refused to agree the account or description written at the time by Dr Sharma and required deletions and editing such that the resulting record was brief, anodyne, and largely uninformative. Nevertheless Dr Sharma agreed to have that typed up for Dr Reiter to sign, as Form 4 and the appraisal process require. This he did, but Dr Reiter returned it unsigned. Dr Sharma was not aware that any personal development plan (PDP), which is a document to be created by the doctor as part of the appraisal, had been returned to the clinical governance department of the PCT. However we have seen a single sheet document submitted by Dr Reiter to the FHSAA in connection with this appeal [A26]. Dr Sharma referred the matter to the PCT because he considered the appraisal incomplete (and so informed Dr Reiter by letter of 16 March 2007). His statement says at paragraph 41:

    "I am aware that there is not a pass or fail standard attached to appraisal but I felt that the content of Form 4 was unacceptable and the evasiveness around it and failure to answer health related questions was enough to raise concerns over the validity of Form 4 and the appraisal itself."

21. The parties then entered into correspondence in which the PCT invited Dr Reiter to sign Form 4, contended that the appraisal process was incomplete, and invited Dr Reiter to meet with them, which he declined to do.
22. In order to address what they perceived as a failure to complete the appraisal process, the PCT formally established an investigation. Dr Reiter declined to meet those conducting it, although there was correspondence between the parties in which Dr Reiter raised a number of points about whether it was proper or lawful for his appraisal documentation to be transmitted by Dr Sharma to anyone else within the PCT and whether the Investigating Officer was properly appointed.
23. Dr Reiter raised a number of further issues in correspondence (in particular his written submissions dated 18 April 2008) which were considered by the PCT Panel which took the decision under appeal. Among other things, he contended that:
    (a) the appraisal was in fact complete and that information about his health was irrelevant to that appraisal.
    (b) the GMC was the competent authority for specific training in general practice for the purpose of implementing European directives, and therefore the PCT was not entitled to request further evidence of training and experience.
    (c) disclosure of any information by Dr Sharma to any other person within the clinical governance team was a breach of Data Protection and European Union legislation and that there had been serial breaches of confidence by individuals acting on behalf of the PCT.
    (d) the PCT's clinical governance team had resorted to harassment and bullying by writing to tell him that they reserved the right to consider referring him to the General Medical Council, should his lack of cooperation persist.
24. These points were dismissed by the PCT Panel which heard the complaint on 24 April 2008, for the reasons set out at R 122-123.
25. By his notice of appeal Dr Reiter raises the following issues:
    (a) There was no evidence that his continued inclusion [in the Performers' List] would be prejudicial to the efficiency of the services which those included in the relevant list perform, adding that he had **never** worked for this PCT.
    (b) There was plenty of evidence to the contrary provided within the report of the Investigating Officer with appendices [R 14 – 76] which was not taken properly into account.
    (c) The PCT Panel had failed to take into account his representations that it had breached its own policies, confidentiality, provisions of the Data Protection Act and European law during the appraisal and later investigation.
    (d) The Panel gave a prejudiced and highly discrediting judgement about him as a doctor and person, without facts to justify it.
26. The PCT's response [R 1- 5] is (in summary) that:

(a) There is ample material within the Investigating Officer's report, Dr Reiter's own representations evidence at the hearing and the findings of the PCT Panel to support the Panel's conclusions. Moreover their findings did fall properly within the description of "inefficiency" in the Department of Health Guidance, namely evidence of "*bad practice, repeated wasteful use of resources that local mechanisms have been unable to address, or actions or activities that have added significantly to the burdens of others in the NHS (including other doctors)".*
(b) The effect of the Appendices 1 – 6 of the Investigating Officer's Report is clear, Dr Reiter's representations were considered and the Panel were entitled to conclude that his responses were inadequate.
(c) The response to (b) is adopted and repeated, on the basis that this ground of appeal is repetitive.
(d) The response to (a) is adopted and repeated, on the basis that this ground of appeal is repetitive.

27. However, the hearing before us is a redetermination, and we are not primarily concerned with the process at the PCT Panel hearing below. We therefore invited the PCT to prove its case
28. The substance of the PCT case against Dr Reiter is to be found in the list of points set out at paragraph 11 of its grounds of opposition [R 4]. It contends that:
    (a) Dr Reiter was aware he was required to sign Form 4 and was aware he had no done so;
    (b) the witnesses paint a consistent picture of Dr Reiter's deep-seated and persistent resistance to the appraisal process and
    (c) his response to PCT officers carrying out regulatory functions was at best uncooperative and at worst rude and aggressive;
    (d) proper and sufficient efforts were made by those involved in the appraisal process to provide reassurance to Dr Reiter that confidentiality would be respected so far as possible to do so consistent with the PCT's regulatory obligations; and
    (e) there was an unnecessary waste of PCT time and resources in trying to complete the appraisal of Dr Reiter.

<u>Evidence for the PCT</u>

29. Wendy Ashford gave evidence. She is employed as an administrator in the PCT's clinical governance team, providing, among other things, administrative support to the appraisal process. She recognised and adopted as true her witness statement at R 18-19. She told us that Dr Reiter had joined the List in the middle of an appraisal cycle and she did not know if he had previously been appraised elsewhere, having no records about him. Therefore she telephoned Dr Reiter on 25 January 2007 to ask if he had had an appraisal for 2006/7, in which case she would have needed his Form 4 for the file. He refused to tell her whether he had had an appraisal or not. He refused to have an appraisal by the PCT. Her statement describes him as abrupt and obstructive and says he could not be coaxed. He would not say where he was working. He stated his constitutional rights were being infringed. Her statement says [para 7] "I felt very shocked at his aggressive manner. I would not like to speak to him again and was worried that I might need to. No doctor had ever before behaved like before in my experience". In her evidence to us she preferred the word "adamant" to "aggressive" although she also told us that he was very rude and obstructive. She told us: "On a personal level I had never been spoken to like this. I had had 3 years' contact [with GPs] on appraisals at that time".
30. Ms Ashford therefore reported to Dr Khan her failure to make progress, and he took it from there.
31. Ms Ashford also produced the copy emails at R 138-140 which reflect messages passed between Dr Sharma, Dr Khan and herself after Dr Sharma had held his appraisal meeting.
32. Ms Ashford told the Panel in answer to direct questions that she simply made the arrangements for appraisals and did not draw Dr Reiter's attention to the fact that an appraisal was a requirement of the regulations under which he was admitted to the Performers' List.

33. We next heard evidence from Dr Satya Sharma, who had in due course carried out the appraisal arranged by Dr Khan. He too recognised and adopted as true his witness statement at R 20 -23. He also produced the copy email at R31-33, sent to Dr Khan on 4 March 2007, some 5 days after the appraisal had occurred. In it, he gave his first account of the problems he had encountered.
34. In his evidence to us Dr Sharma explained that following his appointment as appraiser, he telephoned Dr Reiter at home and Dr Reiter was not pleased to hear from him. He made it clear he was not keen for an appraisal to happen. Dr Sharma offered him a pre-appraisal meeting so that he could give him documents which would be required to be completed in the appraisal, and give him the opportunity to learn about what was involved in the process. He told us that he wanted to give Dr Reiter time to get prepared and to ensure there was no hidden agenda, and that he knew what to expect. Dr Sharma told us that if the appraisee has more questions they get enough time to ask them. This kind of pre-appraisal meeting is not a requirement of the process but Dr Sharma told us it is his practice, particularly if the doctor has not had a previous seminar about appraisals.
35. That meeting was held at Dr Sharma's own practice premises, Bilston Health Centre, on 13 February 2007. The choice of venue was made by Dr Reiter, who preferred that to a meeting at his own home. Dr Sharma described the session as "extremely uncomfortable". He said

    "[Dr Reiter] did not speak much but his body language was "Go away". He refused a cup of tea or drink. He was condescending and treated me in a menial way. I don't mind if he wanted to be in charge. I felt he had not been trained and had not done much GP work and had come from a hospital background and so I was happy to let it go on. I informed him that it was a requirement to have an appraisal and he was not having any of this. I ensured he had all the papers he should have, including Forms 1 to 5 and a Personal Development Plan [template]. There is a standard pack sent to appraisees which contains guidance about what will be done on appraisal – issued by the clinical governance department – and the sort of evidence he will be expected to collect and what he will be asked and the forms I have mentioned." [some pages of this document were included in Dr Reiter's bundle at A 29 and A 33]

36. Dr Sharma's statement says at paragraphs 17 and 18:

    "17. I told Dr Reiter that I would expect to see his reading list. I was not made aware of the date of the previous appraisal. I showed Dr Reiter an example of the evidence which could be used.

    18. Dr Reiter was not happy when he left the meeting but had agreed to the appraisal. He also agreed to provide evidence, and informed me that he had not worked in primary care."

37. Dr Sharma then told us about the appraisal itself. It took place on 27 February 2007, again at Bilston Health Centre. His statement explains that "Dr Reiter was not participative; the usual scenario is that of a 80:20 participation appraisee to appraiser. It was very difficult to get Dr Reiter to talk at all, though I tried to break the ice". He again referred to Dr Reiter's body language. He felt very uncomfortable and told Dr Reiter so. Dr Reiter made no response.
38. In evidence Dr Sharma told us that this meeting did not go as he wanted or expected. Dr Reiter did not talk. Dr Sharma gave him several opportunities to talk about or explain various matters on the forms. Dr Sharma said he made rude responses such as "You can read can't you?" Dr Sharma told us that whenever he encouraged him to talk by asking him to take him through something he had written on the form or explain it more fully, Dr Reiter would say "I mean exactly what I have written". When he asked for details of Dr Reiter's experience, none was forthcoming. Dr Reiter could not understand the relevance to an appraisal of updating his clinical skills. In his statement Dr Sharma says "I asked some questions but Dr Reiter's answers were weird, so weird that I wondered how I could phrase the questions to elicit a proper response. For example I asked about working with colleagues, the response was "working with colleagues means working with colleagues, what does it mean to you?".
39. Dr Sharma asked him to provide evidence for maintaining good clinical standards. Dr Reiter did not have enough, although he did tell Dr Sharma that he had done some academic work. Dr Sharma was not shown the academic papers in question. He said he wished to know what Dr Reiter had read, what he had learned from that and how it would change his clinical

practice. Dr Reiter's response was to say "What has this got to do with it, this is rubbish". Dr Sharma told us he did not think it was rubbish and it was what appraisers were taught.

40. When Dr Sharma asked Dr Reiter about his health, Dr Reiter replied "You are a doctor, you can see." Dr Sharma said he had politely put it to Dr Reiter that he did not have those skills to see his state of health, and thought he could assist him by asking whether his Hepatitis status was OK. Dr Reiter replied "What has that got to do with you? I am not going to answer". Dr Sharma asked about his mental health and physical wellbeing because, as he put it, "Unless you tell me, I cannot know". Dr Reiter refused to answer.
41. Dr Sharma told us "I did my very best. I went a mile further to assist the appraisee to get some of his thinking. When he talked it was irrelevant – he talked about Blair and his cronies trying to do appraisals. He said those people administering the system are Blair cronies and should be ashamed of themselves. He said many things about China and the European Economic Community".
42. Dr Sharma referred to the importance to the appraisal process of documentary evidence, to confirm what doctors were telling the appraiser they had studied. He had explained this to Dr Reiter at the pre-appraisal meeting. Nevertheless none was produced.
43. Dr Sharma said that Dr Reiter did not acknowledge any weaknesses in their discussion.
44. They discussed a Professional Development Plan (PDP). Dr Sharma told us that Dr Reiter had informed him he wanted to obtain a job as a GP with Special Interest (GPwSI) in diabetes or cardiology. Dr Sharma said "I thought that was a good idea but it was a need rather than a professional development: the PDP was not really adequate because he did not outline the overall development he could see." He was later referred to the PDP produced by Dr Reiter at A26. He said "In my assessment the PDP was not adequate. It expresses only 2 wishes and they are inadequate to indicate the development of a doctor. There is a lot of permissible variation but we look at global development. His attention as then drawn to column 2 of the PDP template, entitled "How will I address [my development needs]". Dr Sharma told us that the entries there are inadequate because in respect of 3 out of the 4 developments listed, Dr Reiter has written "I have acquired the knowledge already. I will offer this service". He does not say that there will be any updating or how, or the date by which his knowledge will be updated. Column 3 asks Dr Reiter to say by what date he will achieve a development goal. In Dr Sharma's view 3 of these which state "Shall progress to it once the genuine GP tasks are fulfilled" are vague and unsatisfactory and the information next to the line which identifies "Become a partner to colleagues in a practice" to be achieved "in about 6 months from now" demonstrated lack of a realistic understanding of the steps which would have to be taken to achieve partnership in a GP practice, given that he was not practising at all at present.
45. Dr Sharma told us that Form 4 was required to be completed and signed by both appraiser and appraisee. It is normally completed by the appraiser and the appraisee signs to confirm his or her agreement with it. Its purpose, he said, was to see what has happened in the last 12 months and to identify action for the next 12 months. Dr Sharma told us that he completed Form 4 in Dr Reiter's presence at the end of their session. Dr Reiter had difficulty reading his handwriting and when he understood what had been written he said it was not acceptable, so Dr Sharma changed it. Again Dr Reiter said the revised version was not acceptable so Dr Sharma changed it again. He said "after a considerable time I used words with which he agreed although they were not an accurate reflection of our discussion in my view, but I agreed because it [form 4] has to be agreed, as I understand it."
46. Dr Sharma told us:

    "I told him the procedure was that Form 4, once agreed and signed by both of us needed to be sent along with the PDP to the clinical governance office. This is locally agreed. I told him that once I received them I would submit them to the clinical governance department."

47. At the conclusion of the meeting Dr Sharma told Dr Reiter that his secretary would type up the Form 4 legibly. Dr Sharma checked the typed copy against the handwritten version he had agreed with Dr Reiter and sent it off to him for signature, and to add his GMC number. It was returned in due course altered, unsigned, and without the GMC number.

48. Dr Sharma was asked to look at the pages of Form 4 produced by Dr Reiter. He explained that page A27 was the first page of the form and page 28 was the final page but there were other pages in between, which Dr Reiter had not produced. Dr Sharma explained that the missing pages deal with, among other things, good clinical care, working with colleagues, and maintaining and updating clinical skills. He referred to the following typed comments on that page, which are the only example we have of the record of the appraisal which emerged at the end of the negotiations between Dr Reiter and Dr Sharma:

    "Good clinical care:
    Commentary: Believes in being open with patients.
    Action agreed: No further action required in his own opinion."

    Dr Sharma also referred to the PDP template at A 26 and explained that it had been posted to him by Dr Reiter after their meeting. The procedure was to send it, together with the *signed* Form 4, to the clinical governance department.
49. Dr Sharma was shown R46 which is a copy of his letter to Dr Reiter dated 16 March 2007 and deals with (among other things) concerns expressed by Dr Reiter in a letter of 8 March about the confidentiality of communications sent to Dr Sharma but opened by his secretary. It explains that his secretary is the designated member of staff to open confidential communications and she trained merely to open them but not to read them. It also confirms that Dr Sharma had informed Dr Reiter that only two named people have access to the information in the appraisal.
50. He referred to R 56 which is Dr Reiter's reply of 18 May to his letter of 16 March (a surprising gap). Dr Reiter asked for complete details of what he had sent to Dr Khan and Dr A Phillips. Dr Sharma responded that he had nothing to add to his previous letter.
51. In answer to questions from the Panel Dr Sharma said that there was no CV attached to Form 1, and Dr Reiter had simply indicated he had no experience as a GP. He said that he came nowhere near the standard for an appraisee. For example when asked about what teaching has to be done, he had replied that a teacher will teach what he thinks best. Dr Reiter also said he did his best for his patients. Prescribing was difficult to appraise because there was no prescribing activity to be considered. Dr Sharma had asked about audits but got no reply. He told us that Dr Reiter had no supplementary evidence of any sort about clinical care or practice. He said that A 27 was not a normal first page of a Form 4; normally he put a lot more information into the first and second part (to identify what had been going on and what he had been doing). Dr Sharma said that he had written many more things in detail which no longer appeared on the form, because Dr Reiter was not prepared to accept it.
52. Dr Sharma told us that although he had experience of some GPs who were rather reluctant to be appraised, none of them had ever been rude to him like this. He said that when an appraiser is unhappy with the outcome of the process it is his duty to bring it to the attention of his line manager (Dr Khan in this case). He had not reminded Dr Reiter that he had signed an undertaking to participate in an appraisal; he said "I am just the appraiser; it is not up to me".
53. We next heard evidence from Dr Amjad Khan, who is the GP lead for appraisal in this PCT. He recognised his statement at R 24-25 and adopted it as true. He had spoken to Dr Reiter after Wendy Ashford referred the matter to him. Dr Khan told us that he had offered to go through the process by meeting Dr Reiter, but Dr Reiter was unwilling, so he did it by telephone. Dr Reiter had denied having been appraised before, even in a hospital setting, which surprised Dr Khan because he said all doctors have to participate in an appraisal process. He described how Dr Reiter tried to dominate the conversation, and said among other things that the government had no right to impose appraisal. Dr Khan had explained that it was a Department of Health regulatory obligation but Dr Reiter did not appear to accept this.
54. Dr Khan told us that he looked at all the Forms 4, to identify any trend, and also at the PDPs to see if there was any developmental relationship. He does not want to know who did what, but to detect what training requirements may be necessary. He told us that appraisal is a developmental process, and only the appraiser can decide if the process has been completed to the satisfaction of both parties. He emphasised the information on the forms was accessed by himself and Dr Adrian Phillips (the Clinical Director) only, in the latter case anonymised.

55. Questioned by the Panel, Dr Khan said that he does not see the original Form 4 which simply goes into storage at the clinical governance department. They were all anonymised before being sent to him. In his view the information on page A27 and A 28 was insufficient for a meaningful Form 4 and the PDP was too vague and general.
56. We lastly heard evidence from Lynne Allen, Director of Primary Care for the PCT. She described the investigation process which had been conducted under her supervision, and we were taken through a number of letters and emails in the Respondent's bundle from which it is apparent that Ms Allen sought to arrange meetings with Dr Reiter to address the question of his failure to sign Form 4, but was rebuffed. She also produced the PCT's policy on removal or contingent removal (R68) which echoes the Department of Health Guidelines, and its policy document on the investigation process (R94).
57. Ms Allen told members of the Panel that if she needed clinical advice she would go to Dr Phillips. She also confirmed that she had tried to set up a meeting with Dr Reiter at several points, "to try to take the heat out of the situation" but he refused to meet.
58. Ms Allen also told the Panel that she had concluded Dr Reiter's conduct suggested he would not cooperate at all with the PCT and therefore there was no scope for considering workable conditions for him to remain on the Performers' List. She was asked about what had happened in the remainder of the 12 months since being admitted to the List and she said so far as the PCT was aware Dr Reiter had not worked within the PCT area, nor did he submit himself for appraisal this year.

Review and findings

59. We have considered the oral evidence very carefully in conjunction with all the documents and the submissions received on behalf of Dr Reiter and the PCT. We found each of the witnesses called on behalf of the PCT to be careful and truthful witnesses. Dr Sharma was in our view an impressive witness, who was careful not to state more than his recollection permitted, and remained evidently shaken by the experience of his encounter with Dr Reiter. It was apparent to us that he was a concerned appraiser who was prepared to go the extra mile, as he put in his own evidence, to help a doctor whom he was appraising to do himself justice in the appraisal, and to know what he should be in a position to produce or answer in discussion with the appraiser. It is by no means normal to offer pre-appraisal meetings of the kind he described and he is to be commended for doing so. We accept as accurate the factual narrative of his evidence and the other evidence of the PCT's witnesses. We find each to be consistent with the documentary evidence and with the picture independently painted by the other witnesses.
60. By virtue of his admission to the Performers' list, and thereby gaining access to NHS patients and NHS funding, Dr Reiter was subject to the Regulations and in particular for the purposes of this case the requirement which is contained in Regulation 9 (7). Insofar as it adds anything to that statutory obligation, we also find that Dr Reiter gave a written undertaking to a similar effect when he applied for admission to the List.
61. However, we find that Dr Reiter had from the outset a deep-seated opposition to being appraised, a process which he appears to have regarded as valueless and an unwarranted intrusion into his professional freedom. He cloaked this in a series of highly technical but completely misplaced objections. We find there is no substance in the suggestion that by virtue of having qualified in the European Union he was not subject to the same provisions of the Regulations as affect every other doctor (whether qualified in the UK or elsewhere). It is equally misplaced to suggest that because the GMC has a training role under other regulations (implementing a European Directive) that excludes the operation of the Performers List Regulations which govern the way in which doctors are supervised in the performance of their functions on the Performers' List. These Regulations address a discrete area of concern for the operation of the NHS.
62. Having grudgingly agreed with Dr Khan to have an appraisal, we find that Dr Reiter failed to engage or participate in it in any meaningful way. He turned it into a sham. In accepting the evidence of Dr Sharma we find that a preliminary meeting did take place as he describes, and that Dr Reiter received an information pack as described above, and also received the information which Dr Khan had given him by telephone. Consequently he was fully briefed as

to the nature of the information and supporting documentation he would be expected to be able to produce.

63. We also find that Dr Sharma did explain that the completed appraisal documentation, in particular Form 4 and the PDP, would be sent to the clinical governance department of the PCT (see paragraph 46 above). In agreeing to proceed with the appraisal, Dr Reiter must be taken to have agreed to this element of disclosure, whether or not it was otherwise justified.
64. In any event there is no evidence before us to demonstrate that an improper breach of confidence or of the Data Protection Act in fact occurred. The only documents which were in fact seen by anyone other than Dr Sharma were Form 4 and the PDP. Both were, as we have found, documents which Dr Reiter impliedly agreed should be sent to the clinical governance department, and were also the subject of a local agreement to that effect. We are aware that Form 4 is usually seen by the medical leads. In this case it appears that information was limited to Dr Khan and Dr Phillips and in at least the latter case was anonymised. It is in our view a disclosure which goes no further than is necessary and proportionate to implement the statutory process which the PCT was obliged to undertake.
65. Quite apart from these factual findings, we must consider whether any breach of confidence, if it had occurred, could excuse or make irrelevant the findings set out below as to the failure of Dr Reiter to participate in the assessment. In our judgement any arguable breach of confidence (there being none on our findings) cannot excuse that failure, which had occurred long before anything was done with the appraisal documents about which Dr Reiter complains.
66. A key factual issue is whether we are satisfied that Dr Reiter deliberately failed to "participate in the appraisal system" as he was obliged to do by Regulations 9 (7) (a). We find that he did fail to do so. The process he went through with the PCT and in particular with Dr Sharma could by no stretch of the imagination be called participation. It was perfunctory and obstructive, and there was a failure to engage to any extent which would have enabled Dr Sharma to take a properly informed view about the important range of competencies, skills and needs which make up the appraisal. Dr Reiter never wanted to participate in the process and insofar as he may have grudgingly agreed to do so, he clearly did the minimum he thought he could get away with, but in so doing made a nonsense of the appraisal process.
67. In our view Dr Sharma remained surprisingly helpful to Dr Reiter for a longer period than might have been expected. In view of the attitude Dr Reiter adopted towards him, he might have been justified in calling a halt at an earlier stage. He provided Dr Reiter with the possibility of engaging positively with the process throughout, but unfortunately Dr Reiter did not take the opportunity.
68. In our judgement the documents (in particular Form 4 and the PDP) which emerged from the appraisal were of no informative value and could not have provided the appraiser on the next occasion with any kind of useful benchmark or comparison by which to assess the degree of progress made by the doctor. Form 4 had been emasculated by the several revisions which Dr Reiter had bullied Dr Sharma into making in order to obtain (as he hoped) his signature on the document. The limited information on the single page we have seen is wholly unsatisfactory and inadequate, and the handwritten responses inserted by Dr Reiter on the PDP simply do not properly address the questions in columns 2 and 3. Moreover, Dr Reiter did not identify on the PDP any change to his practice as a result of the development activity, nor was he able to identify any development need. We find this surprising when Dr Reiter had informed Dr Sharma that he had never previously practised in primary healthcare.
69. Ultimately the appraisal was also incomplete, as we find. Dr Reiter failed to sign Form 4 when he returned the typed version which had been sent to him by Dr Sharma, and that was a deliberate omission. The failure to do so was not simply a technical omission. Dr Sharma was entitled and correct to take the view that it was important that Dr Reiter confirmed his agreement to the content of the document by signing it, given the immense problems he had encountered in getting him to participate at all, and then to agree even the anodyne content of the final version of Form 4. It was, sadly, part of a course of dealing with the PCT, in which Dr Reiter failed to cooperate so as to enable the appraisal to be completed properly.

70. We are satisfied that the PCT offered Dr Reiter many subsequent opportunities to sign Form 4, which he failed to do, and this reinforces our view that his failure was deliberate and indeed that he seemed to be washing his hands of the process.
71. Dr Reiter has submitted that Dr Sharma had initially indicated that the appraisal was complete, when he sent his email of 7 March 2007 to Wendy Ashford [R 38]. In the sense that Dr Sharma had finished his part, that is true. This was an internal email rather than a considered document sent by one party to another, and it is clear to us that Dr Sharma was not giving some formal response which was intended to indicate that he could "sign off" the appraisal as satisfactorily completed. It is important to recognise that at that point the typed Form 4 had been sent back to Dr Reiter, but he had not yet returned that document or his PDP. So Dr Sharma was unaware that Form 4 would never be signed or that the PDP would be returned in the form we have seen. We reject the submission of Dr Reiter that Dr Sharma had considered the appraisal satisfactorily concluded but then changed his mind. Dr Sharma was entitled to reflect on what had happened during the appraisal when he appreciated that Form 4 had not been signed, even in its revised form. The formal but important failure to sign Form 4 brings the whole conduct of Dr Reiter in the appraisal interviews into sharper focus.
72. We find that Dr Reiter failed to cooperate with the investigation which was reluctantly launched by the PCT in consequence of his failure to return a signed Form 4. He was given many opportunities to meet with its officers who were keen to "take the heat out of the situation". He would have been better advised to do so and put his side of the story, if he felt it had merit. All he did by his refusal to meet with them was to confirm the developing impression that he was a doctor with whom they could not do business. We are not impressed by, and reject, the technical points made by Dr Reiter as to who was properly appointed to conduct the investigation.
73. We have considered the totality of the evidence with care and are driven to the conclusion that Dr Reiter has shown no insight into the need to comply with regulatory requirements which are not merely intrusive or formalistic, but are designed to maintain the quality and improvement of the services, and ultimately patient welfare. We are unable to identify any evidence of a reasonable, considered and balanced response to the appraisal process and subsequent PCT concerns. At all stages Dr Reiter appears to have been looking for reasons or opportunities to avoid doing the things he was properly required to do.
74. We have considered each of the points made by Dr Reiter, which we summarise at paragraphs 23 and 25 above, and we reject them.
75. In these circumstances, and taking into account the criteria set out at Regulation 11 (5) of the Regulations, we are satisfied that Dr Reiter's continued inclusion in the Performers List would be prejudicial to the efficiency of the services which those included in the relevant Performers List perform. We find ourselves in agreement with each of the matters relied on by the PCT which we have summarised at paragraph 28 above.
76. We have given careful consideration to contingent removal, but we do not find this appropriate in light of our findings about the attitude which underlies his failure properly to participate in the appraisal. There is, we find, a deep-seated attitudinal problem. The relationship between the doctor and the PCT has no reasonable prospect of working (or at least, working without disproportionate and wasteful use of NHS resources) unless there were to be a radical change in that attitude. We see no evidence that that is likely to happen in the foreseeable future. On the contrary, the most recent submissions and evidence from Dr Reiter appear to reinforce our view about his attitudinal problem.
77. We therefore dismiss this appeal and direct that his name be removed from the Performers' List of the Respondent PCT.
78. We direct that a copy of this decision be sent to the persons or bodies identified at Rule 47 (1) of the 2001 Rules.
79. In accordance with Rule 42 () of the Family Health Service Appeal Authority (Procedure) Rules 2001 the Appellant is hereby notified that he may have the right to appeal against this decision under Section 11 of the Tribunals and Inquiries Act 1992. Any appeal shall be made by lodging a notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the receipt of this decision.

DUNCAN PRATT

Chair of the Panel appointed by the FHSAA to determine this appeal

13 September 2008