IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY **CASE 14497**

Professor M Mildred - Chairman
Dr S Ariyanayagam - Professional Member
Mrs V Lee - Member

BETWEEN

DR JAMAL S G MARY
(Registration Number 1404210)
Appellant

and

DUDLEY PRIMARY CARE TRUST
Respondent

DECISION WITH REASONS

Background

1. The appellant ("Dr Mary") is a general medical practitioner who until his suspension by the Respondent PCT ("the PCT") on 4 September was practising at Brierley Hill Health Centre, Brierley Hill, West Midlands as a single handed GP principal. The suspension occurred as a result of a clinical incident in July 2006 arising out of Dr Mary's prescribing to a hypertensive patient awaiting cataract surgery.

2. Before this Dr Mary had been referred for an educational assessment in 2000 and to NCAS in July 2002. As a result of a Qualities and Outcomes Framework ("QOF") visit in November 2004 an investigation was instigated by the PCT followed by a Practice Based Pharmacist's Medication in 2005 and a second QOF visit in December 2005 after which the PCT's Performance Decision Making Committee met and a further referral to NCAS was made.

3. The NCAS assessment was carried out from May to July 2006 and its draft report issued on 30 August 2006. After suspending Dr Mary on 4 September 2006 he was referred by the PCT to the GMC as recommended by NCAS. On 17 November 2006 the Interim Orders Panel of the GMC suspended Dr Mary from practice for 18 months and extended that suspension on 17 July 2008 for a further six months.

Procedural history

4. On 22 January 2008 after a detailed investigation a Professional List Panel ("PLP") appointed by the PCT heard an application to remove Dr Mary from its Performers List and informed him and his Defence Body by letter dated 28 April 2008 to remove him on the ground that his continued inclusion on the List would be prejudicial to the efficiency of the services provided. Dr Mary chose not to attend the hearing and not to make written submissions to it.

5. Dr Mary began an appeal to the FHSAA by a letter dated 4 May 2005 and the PCT by letter dated 13 May 2008 stated that it would contest the appeal. Dr Mary asked by letter that the appeal be dealt with on the papers dated 14 May 2008.

The hearing

6. Accordingly the Panel met on 14 August 2008 to consider the appeal on paper. We confirmed that we had no conflict of interests in dealing with the appeal.

The evidence

7. The PCT produced the following: (a) the case presented to its PLP running to 136 pages, (b) correspondence relating to the PLP hearing and the appeal with minutes of the PLP hearing (30 pages), (c) the Assessors' Report to the GMC dated 15 March 2008 (54 pages) and (d) a ring binder containing 70 appendices including notes of interviews in preparation for the report to the PLP and a copy of the NCAS assessment.

8. Appendix 6 refers to various concerns about Dr Mary dating back to at least 1999 and reports severe gaps in his clinical knowledge as at April 2000 and Appendix 7 an offer of independent educational assessment. Appendix 9 contains a letter from the Deanery dated 6 November 2000 referring to the need for training, professional isolation and a lack of basic understanding of medical audit.

9. A formal assessment of Dr Mary's learning needs by the University of Warwick was reported on 9 October 2001 to show that he was not "risky or seriously worrying" and a mentor was suggested (Appendix 13). The QOF visit report of 29 November 2004 mentioned poor levels of performance 16, serious concerns, the need for support 17 and recommended an investigations into the practice (Appendix 18). There were 13 achievement points in the QOF QMAS claim disallowed for payment and 4 allowed (Appendix 21). The investigation report of August 2005 referred to very poor performance and care of a poor standard (Appendix 23).

10. The 2005/6 QOF visit report disclosed little improvement and raised 10 areas for immediate review or action and recommended 12 additional actions (Appendix 27). A further follow-up to the Performance Decision Making Committee revealed the absence of medication review and monitoring (Appendix 29) and that Committee commissioned further enquiries with a view to a referral to NCAS or the GMC (Appendix 30) and decided on 3 February 2006 on a referral to NCAS 3 (Appendix 31).

11. Appendices 37 and 38 deal with the gross diuretic prescribing error to an 82 year old woman leading to severe dehydration and the risk of impairment of renal function. It appeared to the PCT's prescribing adviser that at least some of the multiple prescriptions were to treat adverse effects of others. Concerns about diuretic prescribing, chronic disease management, antenatal care and diabetic care prompted a decision by the Suspension Panel on 16 August 2006 to suspend Dr Mary (Appendix 44). The draft NCAS assessment disclosed ten areas in which Dr Mary's skills were poor: general practice and care, chronic condition management, infection control, prescribing, record-keeping, use of resources, relationships and communication with patients, team working, keeping up to date and maintaining performance and audit. The assessment was pessimistic about improvement since Dr Mary was resistant to admitting shortcomings and reluctant to change (Appendix 46). NCAS recommended that the PCT refer Dr Mary to the GMC, take any necessary steps (including suspension) to safeguard patient safety, review his patients and give him appropriate professional support. E-mails between Dr Mary and the PCT appeared to show that he was reluctant to accept any criticisms of his practice (Appendices 47-52).

12. Dr Mary made approximately 4 single-spaced A4 pages of comments on the NCAS the vast majority of which were questioning or contradicting the text of the draft report (Appendix 53). The IOP of the GMC suspended Dr Mary (as noted above) for 18 months on 17 November 2006 in the interests of the protection of the public, the public interest and Dr Mary's own interest (Appendix 56).

13. The PCT appointed Eileen Roughton investigating officer. She conducted interviews with the Consultant in Public Health, the former Locality Manager of the PCT, the PCT's Clinical Governance Facilitator, two prescribing advisers, a practice based pharmacist and a GP all of whom were familiar with Dr Mary's practice in compiling her report to the PLP.

14. The allegations (backed as mentioned above by 128 pages of evidence) of lack of acceptable standards of clinical knowledge, skills and performance against Dr Mary arising out of that investigation related to prescribing (5 sub-allegations), infection

control, diagnosis and follow-up of long-term conditions, record-keeping, referral (3 sub-allegations), keeping up knowledge and professional development, failure to train or develop practice staff, communication skills and general professional good practice. The long duration of the concerns, the number of assessments conducted, serious clinical concerns, support offered to Dr Mary and his failure and/or resistance to change were also relied on. It quoted from the NCAS report that Dr Mary did not have the insight into the longstanding concerns about his ability and that the long history and lack of insight made it unlikely that an intensive remediation programme would be successful.

15. The PLP unanimously found all these allegations proved and decided that Dr Mary should be removed from the Performers List on the grounds of efficiency and unsuitability.

16. We have recently been provided with the Assessors' Report to the GMC. It does not appear to have been produced at the PLP and therefore, pursuant to Rule 41(7) of the Family Health Services Appeal Authority (Procedure) Rules 2001, we are unable to consider it.

17. We have not seen or heard from Dr Mary and we have very little from him in writing. There is some correspondence with his Defence Body (MDDUS) but only in relation to Dr Mary's health, the timing of the PLP and a notion that he might be considering retirement. There was no written submission from him before the PLP.

18. In relation to the appeal the total evidence supplied to us does not exceed three pages of single-spaced A4 typescript. In his letter of 4 May 2008 Dr Mary made the following points: (a) he passed the University of Warwick assessment (similar to MRCGP and NCAS); (b) NCAS examined only 27 records and made a good number of mistakes; (c) the decision was based on the desire to close a small practice; (d) he was not allowed separate space from the next door surgery that would have improved patient confidentiality.

19. In his letter of 23 June he said (e) he wanted to work as a locum and not to go back to his old practice; (f) the PCT's refusal to give him extra space had diminished the effectiveness of his practice and increased its stress levels; (g) the 1999 assessment had been caused by typing mistakes by a secretary in referral letters to a consultant gynaecologist; (h) local GPs who had assessed his practice had been threatened with losing their jobs, if they did not comply with the PCT; (i) his difficulties with the 2004/5 and 2005/6 QOFs arose from inadequate computer training provided by the PCT and allowance should have been made for this and the small practice size; (j) by September 2006 matters had improved; (k) he had always communicated well with the practice based pharmacist who was also threatened with job loss, if he would not give Dr Mary a bad reference; (l) after 4 September 2006 a "disarray" happened to the practice although all patients were satisfied with it before that date – other doctors asked about it must also have been threatened with losing their jobs and (m) Dr Mary had been informed by his receptionist that all this happened because he did not marry an English woman.

<u>Discussion and findings</u>

20. We approach this appeal in the knowledge that Dr Mary has terminated his contract with the PCT, has begun to take his retirement benefits and wishes simply to be able to act as a locum (rather than return to full-time general practice). In the light of that points (c), (d) and (f) in paragraphs 18 and 19 seem to us to be of little importance: the questions are whether Dr Mary is suitable to practise and whether his practice as a potential locum would be prejudicial to the efficiency of the PCT's service.

21. We conclude that there is a long history of inadequate practice going back to at least September 1999 and a referral to the GMC in June 2000. In November 2000 after an educational assessment fundamental shortcomings were identified by the Deanery.

The QOF process identified an unusual number of areas requiring improvement such that the acute prescribing incident of July 2006 cannot have been unexpected.

22. The NCAS assessment identified many important shortcomings heavily outweighing examples of good practice (see paragraph 14 above) in all key areas of modern general practice and the report before the PLP made a similar and overwhelming case on the efficiency ground.

23. Against all this we have only the riposte from Dr Mary referred to at paragraphs 18 and 19 above to which we now turn, using the same sub-headings.
In relation to (a) we accept that in 2001 the University expressed this view but consider that it should be overtaken by more recent and more detailed assessments and events.

24. In relation to (b) we do not consider the sampling undertaken by NCAS to be inappropriate and we are quite unconvinced by the bare allegation that NCAS "made a good number of mistakes for not inspecting them properly" without any detailed reasoning. In relation to (e) we accept that Dr Mary only wishes to work as a locum. That cannot, however, affect the standard to be required of any general practitioner undertaking any general practice: we cannot treat locum work as tantamount to a hobby. We do not accept point (g) since Dr Mary was responsible for the referral and, even if the typographical errors played any part in the cause of the problem, he should have spotted and corrected them.

25. Points (h), (k), (l) and (m) amount to or contain allegations that individuals acted in bad faith under pressure from the PCT to give false evidence against Dr Mary. It is simply not good enough to make generalised allegations of this sort without any evidence, written or oral, to justify or even explain them in detail and we reject them.

26. In relation to point (i) we do not accept that lack of computer training was the sole or main cause of Dr Mary's poor QOF scores: in any event it was open to him to have sought more training or brought in expertise from elsewhere. In relation to (j) we have not been referred to any evidence of improvement by September 2006: we conclude, on the contrary, that the picture is of a declining state of affairs.

27. In relation to (l) it is quite inappropriate to refer the suspension of 4 September 2006 as a "disarray" before which all patients were satisfied with the practice. Apart from the profound and wide-ranging criticisms by NCAS the GMC was subsequently itself satisfied that suspension from the Register was necessary and continues so to be satisfied.

28. In the light of these findings we have no difficulty in concluding that Dr Mary's continued inclusion on the PCT's Performers List would be prejudicial to the efficiency of the services performed by its members. The question remaining is whether there should be a contingent removal to permit Dr Mary to improve his performance to the standard at which he could perform efficiently as a locum.

29. It must be recognised that Dr Mary has given long and loyal service to the NHS and has satisfied many of his former patients. That is not, however, the test we must apply. As set out in paragraph 11 the NCAS assessment was pessimistic about improvement in view of Dr Mary's resistance to admitting shortcomings and reluctance to change. These factors classically militate against the ability to remediate rusty skills and obsolete practices. There is no doubt that the PCT supported Dr Mary over almost a decade with attention and resources (including a mentor) and did not rush to the application to remove him from the List.

30. We are also pessimistic that Dr Mary's practice is remediable by re-training and supervised practice: the picture we have is of a GP who has not kept pace with the changes to modern general practice and has slipped further and further behind as the last decade has passed. In addition we are a little influenced by the apparent ambivalence of Dr Mary in the conduct of his appeal. If he had been serious about

restoration to the List for locum purposes, we would have expected vastly more detail of his defence to the allegations and full evidence of his attempts since his suspension to re-educate himself in the areas where respected outside bodies had found him wanting. The reality is that Dr Mary has been out of practice since September 2006, almost two years, and is suspended by the GMC so that he could not begin any re-training for about another six months at a minimum. In the meanwhile medicine and general practice have continued to change and we are not persuaded that Dr Mary would be able to bring himself up to the necessary standard.

31. For the reasons set out above we are of the view that the appeal should be dismissed and we order that Dr Mary should be removed from the PCT's Medical Performers List on the ground of efficiency.

32. We direct, pursuant to Rule 47(1) of the Family Health Services Appeal Authority (Procedure) Rules 2001 that a copy of this decision is sent to the Secretary of State, The National Assembly of Wales, the Scottish Executive, The Northern Ireland Executive and the Registrar of the General Medical Council.

33. Any party to these proceedings has the right to appeal this decision under and by virtue of Section 11 of the Tribunals and Inquiries Act 1992 by lodging notice in the Royal Courts of Justice, Strand, London WC2A 2LL within 28 days from the date of this decision.

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Mark Mildred
Chair of Appeal Panel
15 August 2008