IN THE FAMILY HEALTH SERVICES APPEALS AUTHORITY No: 14671

IN THE MATTER OF AN APPEAL UNDER THE NATIONAL HEALTH SERVICE (PERFORMERS' LIST) REGULATION 2004

Miss Siobhan Goodrich: Legal Chair
Dr Rafik Sadek: Professional Member
Mr Bill Nelson: General Member

Heard at: The Care Standards Tribunal
On 18th, 22nd, 23rd, 24th May and 27th and 28th July 2009

BETWEEN:

Dr VINOD MOUDGIL
(General Medical Council Registration Number 2355568)

Appellant

and

WANDSWORTH TEACHING PRIMARY CARE TRUST

Respondent

Representation
For the Appellant: Mr Simon Cridland, Counsel, instructed by Radcliffes
For the Respondent: Mr Paul Ozin, Counsel, instructed by Capsticks

DETERMINATION

The Appeal

1. Dr Vinod Moudgil appeals against the decision of the Wandsworth Teaching Primary Care Trust (hereafter referred to as "the PCT") made on 4th July 2008 to remove his name from its Performers' List. The decision, made under paragraph 10 (4) (a) and (c) of the National Health Service (Performers' List) Regulations 2004 ("the Regulations") was that the continued inclusion of Dr Moudgil's name in the Performers' List would be prejudicial to the efficiency of the services that those in the relevant list perform and that he was also unsuitable to be included therein.

The Background to the PCT Decision

2. In December 2002 Dr Moudgil joined the Alton practice in Wimbledon where Dr Alissa was senior partner. In 2006 Mr Nick Beavon, the Chief Pharmacist at the Trust, received concerns about Dr Moudgil's use of Fexofenadine from Dr Alissa, on behalf of the practice, and from Juby Hameer, the local community pharmacist. Mr Beavon investigated the issue and prepared various reports for the PCT. Members of the practice also provided written reports from the Alton practice detailing various concerns in relation to Dr Moudgil's practice. These matters led the PCT to commission a review of records which was carried out by Dr Corlett, a former GP principal and current Primary Care Medical Director at

Newham PCT. Over a period of two days Dr Corlett considered some 41 sets of patient records which were randomly selected. In addition she considered therein a number of cases that had been selected by the practice. She set out matters that gave her cause for concern in a report (the Acredita report) dated 3rd December 2007. All the above material was before the PCT panel who considered the issue of removal on 30th June 2008. Dr Moudgil did not attend the PCT panel hearing and was not represented: he had requested an adjournment on the grounds of ill health, which request had been refused.

The PCT decision

3. The PCT decided to remove Dr Moudgil on the grounds of efficiency and unsuitability. The reasons for the decision were essentially as follows:

"*1. The allegations contained in the report provided by Dr Moudgil's partner, Practice Manager, Practice Nurse and local pharmacist. were largely substantiated by the report of the Independent Medical Records Review carried out by Acredita (Appendix 9).*

2. Of the 48 sets of medical records reviewed by Acredita;

- *42 sets of records showed examples of poor practice;*
- *41 sets of records were highlighted as a cause of concern with regards to clinical decision-making;*
- *20 sets of records were highlighted as a cause of concern with regards to examination and diagnosis, including appropriate investigations;*
- *In relation to 31 sets of records, it was found that it would be difficult for another doctor to take over the care of the patient on the basis of the notes;*
- *One particularly concerning case involved your failure to prescribe insulin when it was clearly required.*

3. In the light of the findings by Acredita you have failed to comply with the following criteria set out in the Good Clinical Care section of the GMC Good Medical Practice Guide 2006 which states;
"Good clinical care must include;
Adequately assessing the patient's conditions, taking account of the history (including symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient; …
(c) provide effective treatments based on the best available evidence; …
(f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment."

4. There are serious and wide-ranging failings in your performance, including inadequate clinical decision-making and prescribing which does not follow evidence based practice or established guidelines, inadequate record-keeping, over-treatment of minor and self-limiting illness, a failure to assess or manage potentially serious symptoms safely and unjustified diagnoses of chronic disease."

4. In reaching its decision the PCT Panel said that it took account of issues including the public interest, the seriousness of the clinical failings identified which go to patient safety, and the fundamental nature of the failings in the context of performing primary medical services.

THE APPEAL

Pre hearing Decisions and Directions

5. Dr Moudgil's representatives lodged a brief letter which indicated that Dr Moudgil wished to appeal. Directions were given on 6th October 2008 and the appeal was listed. At the hearing on 6th November 2008 Dr Moudgil did not attend. The panel heard and decided the preliminary points raised which amongst other things, related to: whether the PCT should have allowed the Appellant's request for an adjournment of the hearing on the grounds of ill health, whether the FHSAA had power to remit the matter back for decision, or whether the appeal should be postponed whilst Dr Moudgil underwent the planned performance assessment in the GMC fitness to practice process which was underway. We refer to the determination dated 21st December 2008 which sets out the full background and our decision on the issues that were pursued.
6. The issue of whether the PCT panel should have adjourned the hearing was again taken up in the amended Notice of Appeal which was then lodged pursuant to directions. At a further case management hearing on 12th February 2009 further directions were given including leave to the Appellant to adduce psychiatric evidence. In the event, the Appellant decided not to adduce any psychiatric evidence at the hearing.
7. At the request of the parties further case management directions were given by the Chair on 26th May 2009.
8. At the hearing any issues relating to whether the PCT panel should have adjourned the hearing on the basis of ill health were not pursued before us and we were not asked to consider this issue.

The Documentation

9. The following paginated and indexed bundles were before us:
    (1) The core appeal documents
    (2) Witness Evidence
    (3) Prescriptions
    (4) Medical Records

10. During the hearing we were provided with *"Good Medical Practice for General Practitioners"* published by the Royal College of General Practitioners in 2002.

THE HEARING

Our approach to the evidence

11. This appeal is a civil proceeding and the procedures are governed by the Family Health Services Appeal Authority (Procedure) Rules 2001 ("the Rules"). It was agreed by both parties that the nature of the appeal is by way of redetermination**:** it is open to this panel in its redetermination to make any decision that would have been available to the PCT. Our task is not that of review of the panel decision but to make our own in the light of the evidence before us.

The Evidence

12. **The PCT:** We heard evidence from members of the Alton Practice: Dr Alissa, senior partner; Mrs Alissa, practice manager; Angelica Chicos, practice nurse. We also heard from Juby Hameer, the local community pharmacist, and Mr Beavon, the Chief Pharmacist at the Trust, who was factually involved in discussion with Dr Moudgil as to his prescriptions for Fexofenadine. Mr Beavon also prepared reports based on his review of a number of prescriptions which

were treated by all as expert evidence. We heard independent expert evidence from Dr Corlett.

The Appellant: We heard evidence from Dr Moudgil over two days as well as evidence from Dr Silk, an independent expert in General Practice.

13. It is unnecessary to summarise the evidence of the witnesses since it is set out in their statements/reports which stood as evidence in chief. When making our findings of fact we will refer to the principal aspects of the factual and expert evidence that were in issue in the context of our findings and our consideration in overall context.

The Burden and Standard of Proof.

14. We directed ourselves that the PCT bore the burden of proof. It was agreed that the facts should be determined by applying the civil standard of proof.

Submissions.

15. We received comprehensive written submissions from Mr Ozin for the PCT and both oral and written submissions from Mr Cridland on behalf of the Appellant. On 27th July 2009 the PCT was represented by Ms Rumble who replied to the Appellant's submissions. We do not attempt to set out each and every matter upon which the parties relied. The key features of the respective positions of the parties may be summarised as set out below.

The Respondent's case

16. The Respondent's position is that the only appropriate disposal is removal on the grounds of unsuitability and/or inefficiency and that contingent removal is not an appropriate option.

17. Having addressed the evidence in respect of those matters in dispute, the PCT contends that individually and collectively, these were serious incidents. Dr Moudgil's dangerously idiosyncratic prescribing practices and a lack of acknowledgement and insight into errors display deep-seated attitudinal problems. It is not possible to formulate practicable conditions capable of removing any prejudice to the efficiency of services. Notwithstanding Dr Silk's view, there is no good reason to conclude that Dr Moudgil's attitudinal problems are remediable. A long period out of work with time to reflect on the opinions of distinguished colleagues has not caused Dr Moudgil adequately to acknowledge his errors. Consequently, any supervision sufficient to ensure that his practice is safe would amount to supervision of practically all aspects of his practice. Similarly, any retraining would be long and expensive. Both would require disproportionate expenditure and use of resources. There is no suggestion that there are any relevant and remediable physical or mental health issues, the Appellant having chosen not to adduce any expert evidence in the appeal hearing in this regard.

The Appellant's case.

18. Although many of Dr Corlett's criticisms have some justification and were admitted by the Appellant, others were either unfair and/or unreasonable when placed in their particular context or, alternatively, were over stated in terms of their alleged seriousness. The grounds of unsuitability do not properly apply in this case as a matter of construction since the regulations are directed to misconduct or behaviour of a criminal type. Even if such was not the case, the evidence did not suggest that the Appellant had deep-seated or personality problems such as to render him unsuitable to remain included.

19. The Appellant accepted that the efficiency grounds were established and that a period of retraining was warranted. He is a doctor of long standing who has devoted a very considerable portion of his life to the treatment of patients within the NHS. It was clear that Dr Moudgil wished to do his best for his patients and that he had insight. In the light of all the evidence the reasonable, fair and proportionate response is that of contingent removal thereby allowing him to retrain whilst protecting the public interest.

The Fexofenadine issue

20. The Appellant's stance has always been that the issue of the Fexofenadine prescribing had been previously dealt with by the PCT and that it was unfair to subsequently resurrect it as a ground for removal from its list. The Appellant did not seek a preliminary ruling in this issue. We examine the submission on its merits.

21. We find that the sequence of events was as follows. Mr Beavon had concerns about Dr Moudgil's use of Fexofenadine brought to his attention by Dr Alissa and Juby Hameer. In the event he discovered by looking at ePACT data that Dr Moudgil's practice was far out of line with other practices in the area. The results of his search for prescriptions for Fexofenadine issued by Dr Moudgil ran to several hundred. As evidenced by the chart he prepared, Dr Moudgil's use of the drug was not seasonal as is normally the case with an antihistamine.

22. Mr Beavon wrote to Dr Moudgil on 28th June 2006 regarding the extremely high use of Fexofenadine apparently prescribed by him [2/63].They spoke by telephone on 30th June 2006 when Mr Beavon recorded that Dr Moudgil said that Fexofenadine was a good antihistamine with few side effects and no cardiac side effects. Dr Moudgil said that it was being used for rhinitis and allergic conditions only. When Mr Beavon then related that Juby Hameer said that patients had asked her why they were being prescribed an antihistamine for back or neck pain, Dr Moudgil said that he was doing a study. When pressed by Mr Beavon as to whether the patients were being treated for allergy related conditions Dr Moudgil then said that he was doing a study into the causes of head and neck pain as part of his PDP (Professional Development Plan). When asked if he had obtained the approval of the Ethics Committee and patient consent as required in a clinical trial, Dr Moudgil told Mr Beavon that the study had not got to that stage but that he was going to submit a protocol next month [2/64].

23. On 30th June 2006 Mr Beavon was telephoned by Ms Hameer who had been visited by Dr Moudgil that day. He recorded her account of his visit.

24. Mr Beavon wrote to Dr Moudgil on 4th July 2006 [2/66] asking him to confirm whether he had obtained consent from patients treated, to provide a copy of the study protocol, and for an explanation as to the rationale for prescribing Fexofenadine for aches and pains. Dr Moudgil was advised that the PCT Primary Care Contractor Performance Group required a written response by 4th August 2006. Mr Cridland submitted that it was therefore clear that the matter was being formally considered and investigated by the PCT.

25. Dr Moudgil responded by letter dated 3rd August 2006, but neither side has been able to produce a copy of that document before us. Mr Doug Middleton, the Associate Director of Primary Care Management Development and Support, wrote to Dr Moudgil on 15th August 2006 [2/67] advising that until Ethics Committee approval was received he should desist from the clinical trial. Mr Middleton also encouraged Dr Moudgil to review the patients that had been

involved in this "trial" to ensure that they were in receipt of treatment appropriate to their condition.

26. Mr Cridland submitted that on a natural and reasonable reading, this letter constituted a final determination of the matter by the PCT and was understood by Dr Moudgil to be such [2/15]. He contended that it is therefore impossible to see why the PCT should be permitted to re-open the issue of the Fexofenadine prescribing as a ground for removal of Dr Moudgil from the Performers' list.

27. As indicated above in paragraph 2 above, it was the Fexofenadine issue that led the PCT to closer enquiry into Dr Moudgil's practice in general. As Mr Cridland accepted, it could not argued that the PCT were estopped from considering Dr Moudgil's practice in prescribing Fexofenadine when considering his removal: there had been no hearing and no finding made on this or any other issue. Mr Cridland submitted that it was simply unfair for the PCT, and consequently for us in our redetermination, to take Dr Moudgil's practice re Fexofenadine into account because Dr Moudgil had thought that this specific matter had been satisfactorily resolved.

28. We see nothing in the correspondence that could reasonably be taken to suggest that Dr Moudgil's use of Fexofenadine was a matter that would not be considered further, or that it contained any indication that if he desisted the matter would be considered as resolved. In point of fact he was advised only by Mr Middleton that he should not continue with the clinical trial until he obtained Ethics Committee approval. Further we consider there was a clear risk to the interests of patients that Mr Middleton needed to address. Had he failed to write as he did he would have failed in his duty to address the immediate issue. Firstly Dr Moudgil was apparently conducting a trial involving the unlicensed use of a drug without having obtained prior approval of the Ethics Committee or fully informed consent (in a format approved by that Committee) from each patient. Secondly there was a legitimate and ongoing concern as to whether patients were receiving treatment appropriate to their condition.

29. It might be said that the PCT could have made it crystal clear to Dr Moudgil that his use of Fexofenadine would still be under consideration but we do not consider that there is any real substance to this in proper context. It is not suggested that Dr Moudgil would have acted any differently had he understood that the general implications of his use of Fexofenadine were under consideration. The PCT was under an obligation to investigate the general matters of concern that were emerging, of which Fexofenadine was a part. Although not put this way, we have considered whether any legitimate expectation was raised that the Fexofenadine issue would not see the light of day again. We conclude that no such expectation arose. We do not consider that fairness requires that the Fexofenadine issue should be excluded from our consideration. We have also considered Regulation 11(7) which requires the decision maker to consider *"the overall effect of any relevant incidents and offences relating to the performer of which it is aware".* In our view this is wide enough to include any matters of which the PCT are aware, even if the practitioner has ceased his practice in this particular regard.

Our consideration of the evidence and findings of fact.

30. The Appellant qualified from the University of Punjab in 1971 and rose to the position of Senior Resident in General Surgery in India. He came to the U.K. about 1978 where he worked in NHS hospitals posts including posts at Senior Registrar level in general, orthopaedic and urological surgery. In 1992 he decided to move into General Practice. He completed the vocational training which included 9 months psychiatry, 6 months Obstetrics and Gynaecology and

1 year as a GP Vocational Trainee. He entered General Practice in 1993 in the East End of London.

31. Dr Moudgil joined the Alton Practice in December 2002. He came with good references. According to Mrs Alissa everything went well for the first year and then it was noticed that Dr Moudgil was prescribing medication in an unusual way and that he was prescribing Fexofenadine a great deal and for a variety of symptoms. She described an occasion when Dr Moudgil prescribed Fexofenadine to her when she asked for ear drops to soften wax in her ear so that it could be syringed.

32. Dr Alissa [2/4] related that after the first year or so he had a number of concerns: he was made aware of patient concerns that they had been prescribed Fexofenadine inappropriately and without reasonable explanation and he was approached by Juby Hameer. When he asked Dr Moudgil about both the Fexofenadine prescribing and the commissioning of Immunoglobulin E (IgE) tests, Dr Moudgil told him that he was doing research for his personal development plan on the effect of Fexofenadine on neck and back pain. Dr Alissa asked Dr Moudgil whether he had obtained ethics approval and the consent of the patients. Dr Moudgil said that he had the patients' consent but that it was premature to obtain ethics approval as he was still gathering data. As a result, Dr Alissa reported his concerns to Mr Beavon.

33. We have already set out the broad sequence of events in relation to Mr Beavon's factual involvement. There was no challenge to his account.

34. The areas in which there was significant conflict between the evidence of the other factual witnesses and that of Dr Moudgil were relatively narrow. We deal only with those that are germane to our decision.

The evidence of Juby Hameer on the prescriptions of Fexofenadine and antibiotics.

35. In her statement Ms Hameer described an occasion in early 2006 when, having supplied Fexofenadine prescribed by Dr Moudgil, the patient returned the medication to the pharmacy. The patient said that he had gone to Dr Moudgil with neck pain and wanted to know why Fexofenadine, an antihistamine, had been prescribed. Ms Hameer suggested that the patient return to the practice for advice. A day or so later she saw Dr Moudgil and mentioned the matter to him. Dr Moudgil told her that he knew that the drug was not licensed for neck pain but that he was conducting a research project and the patient knew this. Ms Hameer said that she was surprised by this but she did not feel the need to take it further as her experience of Dr Moudgil was that he tended to justify things rather than accept mistakes,.

36. Ms Hameer described how as a result of this she became slightly wary of prescriptions issued by Dr Moudgil and began to take extra care in checking them. Over the next month or so another four or five patients came to the pharmacy raising concerns about having been prescribed Fexofenadine. In most cases the patients said that they had read the package leaflet and could not understand why they had been prescribed an antihistamine for neck or shoulder pain. Ms Hameer asked one patient whether Dr Moudgil had mentioned being a part of a research trial and was told that Dr Moudgil had mentioned something. The effect of her evidence is that the patient was nonetheless sufficiently concerned to return the medicine to the pharmacy. Mrs Alissa also asked Ms Hameer why she had been prescribed Fexofenadine for an ear problem: Ms Hameer advised her to speak to her husband.

37. Some months after the Fexofenadine issue arose, Ms Hameer received a prescription from Dr Moudgil for Amoxicillin 125mg/5ml to a child. The dose prescribed was 1.25ml (31.25mg) three times a day whereas the normal dose for a child aged two and a half would have been 125mg/5ml three times a day. When she telephoned Dr Moudgil he said that the child was premature and therefore needed a lower dose.

38. Shortly afterwards she received a similar prescription of Amoxicillin for a two year old. The mother confirmed that the child had not been born premature. Ms Hameer considered the dose prescribed to have been so low as to be ineffective.

39. Mr Cridland asked Ms Hameer whether she had dispensed in accordance with the prescription. She said Dr Moudgil had provided an explanation on the first occasion and it was not for her to question his rationale. She was concerned because, having thought the matter through, she could not see that the effects of prematurity would still be operative two years after birth. Shortly after the second incident she had checked the BNF and had called the National Pharmacy Association for advice which led her to raise the matter with Dr Alissa. Ms Hameer said that there was an issue with Dr Moudgil around communication because he always had an answer and as she was very busy it was easier to accept what he said.

40. On another occasion Dr Moudgil prescribed Nystatin suspension at a dose of 0.25ml. Ms Hameer considered that the usual dose in a child would be 1ml four times a day or, if prescribed to new born babies, 0.5ml three or four times a day. She contacted Dr Moudgil because the dose was too small to measure into the 0.5 and 1ml marked dropper provided, let alone to be effective. Dr Moudgil said that he intended to prescribe this dose because the patient was a premature baby and, if necessary, Ms Hameer should provide a syringe.

41. In cross examination Ms Hameer was asked about Mr Beavon's record of her conversation with him about Dr Moudgil's visit to the pharmacy on 3rd July 2006. In this Mr Beavon had related that she had told Dr Moudgil that she had no problem save with respect of his prescribing of Fexofenadine. *"(Dr Moudgil) said that sinusitis is an inflammatory condition so Fexofenadine could be used for aches and pains. He said that if patients query prescribing they should be sent back to him. He then stormed out."* In answer to Mr Cridland Ms Hameer said that she had two concerns: the use of fexofenadine, and the prescription of antibiotics at sub-optimal doses. However, when Dr Moudgil came in on 30th June the focus was Fexofenadine. He had stormed in and the pharmacy was busy. She had never seen him as angry as that day and she was taken aback.

42. Ms Hameer then went on to say in cross examination that when they had had discussions before Dr Moudgil had said *"My dear, I know the BNF backwards so don't tell me what's in it"* or words to that effect. She agreed that this had not been in her witness statement because she had not recalled it at the time that her statement was made. She agreed that she had reflected on events since.

43. In answer to the panel's questions Ms Hameer said as the practice was next door she would pop in to speak to the doctors about any issue arising with a prescription so that any changes could be made then and there. She had cause to contact Dr Moudgil more frequently than she would have liked. It was difficult to talk with Dr Moudgil because he had an air of aggression and a ready answer for everything. Asked if this was peculiar to Dr Moudgil or the practice she said that she had never had experience of a GP who was so belligerent. She recalled that the problems with Fexofenadine had come to an end. So far as

sub-optimal doses of antibiotics were concerned this varied: on some days there were no issues arising but on others there would be 3 or 4 prescriptions that appeared to be sub-optimal doses. After being told that the doses were correct because the child had been premature a few times, she had not contacted Dr Moudgil again. After the outburst when Dr Moudgil came in to the pharmacy in July 2006 she only dealt with Dr Alissa.

Dr Moudgil's evidence on Fexofenadine as well as the issues raised by Juby Hameer.

44. As opened, the Respondent's case was that Dr Moudgil conducted a private clinical trial without Ethics Committee approval. In evidence before us, Dr Moudgil's initial account was that he only ever prescribed Fexofenadine when, in his view, the clinical presentation of the patient justified, on a conventional appraisal, the prescribing of antihistamines to address an allergic reaction. It is suggested that this is an ex post facto reconstruction designed to present some kind of rational basis for the treatment given and/or to bring it within the uses for which the drug is licensed.

45. In his evidence Dr Moudgil denied that he had ever had any conversation with Juby Hameer concerning a patient who had returned a supply of Fexofenadine to the pharmacy. Ms Hameer's evidence if reliable suggests that Dr Moudgil prescribed Fexofenadine for neck pain simpliciter.

46. We noted that Ms Hameer had not included in her statement some of the detail that she gave when asked specific questions in cross examination. We noted also that her statement was relatively brief and to the point. We do not consider that she embellished or exaggerated her evidence when responding the questions asked. It was evident from both the content of her evidence and her manner in which she gave it that she took no pleasure in criticizing a fellow professional and that the further detail she gave was in response to the challenge to her account. We found her to be a reliable witness and accept her evidence. We noted that Dr Moudgil also denied that he had been angry and stormed into the pharmacy on 3rd July 2006, but we accept that this occurred.

47. We were appropriately cautious when considering the evidence of the practice witnesses. Dr Alissa's account was essentially unchallenged in cross examination. The issue between Mrs Alissa and Dr Moudgil was the nature of her symptoms when she was prescribed Fexofenadine. Dr Moudgil's case was Mrs Alissa complained of symptoms which, following examination, he had attributed to pharyngitis. He considered that he was justified in prescribing Fexofenadine because of his view that Mrs Alissa's condition could be related to an allergic reaction, and was all related to *"throat and Eustachian tube syndrome".* Mrs Alissa said that she had consulted Dr Moudgil because she wanted ear drops to soften wax in her ear. She agreed that Dr Moudgil did examine her ears but denied that Dr Moudgil had made any mention of her condition being due to pharyngitis or throat and Eustachian tube syndrome.

48. We considered whether the fact that Mrs Alissa had consulted Dr Moudgil at all suggested that she was seeking confirmation of pre existing concerns. She told us that she had always consulted another doctor rather than her husband. We accept her evidence that she had been a patient of Dr Moudgil's predecessor. She said that although she could have obtained ear drops over the counter she did not do so because she had a pre paid prescription certificate. The fact is that it is not disputed that Dr Moudgil prescribed Fexofenadine to her. We consider that if this consultation had been a "trap" it would be more likely that her symptoms would have echoed those of other patients who had said they been prescribed for neck or back pain. We noted also that Mrs Alissa had asked Ms

Hameer about the prescription that she had received which tends to suggest that she had not talked to her husband about Dr Moudgils' prescription or her own health. We conclude that she had consulted Dr Moudgil for a genuine reason. Mrs Alissa agreed that Dr Moudgil examined her ears. We prefer her account of the consultation to that given by Dr Moudgil. We find that she did not complain of symptoms that could have reasonably been attributed to pharyngitis and that no mention was made of this or any other condition by Dr Moudgil.

49. We have considered the accounts first given by Dr Moudgil when challenged in relation to his use of Fexofenadine.

50. We accept Dr Alissa's evidence that when he raised the issue with him Dr Moudgil said he was doing research for his personal development plan on the effect of Fexofenadine on neck and back pain.

51. We noted that when initially challenged by Mr Beavon, Dr Moudgil said he used Fexofenadine for rhinitis and allergic conditions *only* - until Mr Beavon disclosed that he was aware of Dr Alissa's account concerning the study. We accept Mr Beavon's evidence that when he pressed Dr Moudgil as to whether the patients were being treated for allergy related conditions, Dr Moudgil then said that he was doing a study into the causes of head and neck pain as part of his PDP (Professional Development Plan). We noted that soon after the conversation with Mr Beavon, Dr Moudgil told Judy Hameer that sinusitis is an inflammatory condition so Fexofenadine could be used for aches and pains. We noted that in his evidence Dr Moudgil denied that this was an accurate account of his conversation with Ms Hameer on 3rd July. We consider it likely that Ms Hameer's account of what Dr Moudgil had said was accurately recorded by Mr Beavon, and that it reflected Ms Hameer's recollection soon after the events.

52. We have not seen Dr Moudgil's professional development plan or any other evidence to show the basis or rationale of his theory. We noted Dr Moudgil's evidence that he had been told by the Deanery that he did not need Ethics Committee approval for his personal professional development plan. It would seem unlikely that any such advice would have been tendered if the Deanery had been aware that it was intended that an antihistamine would be used to treat neck or back pain. We noted that when cross examined further on this issue Dr Moudgil said that his PDP was to look at neck and back pain and that it was not originally connected with Fexofenadine. Dr Moudgil said that this had developed thereafter when patients came with neck and back pain symptoms that, on enquiry, were related to allergies. He said that he regarded himself in an ethical situation because he had to treat the symptoms patients presented. He maintained that there was no orthodoxy in patient treatment and that it was legitimate for him to use the knowledge and experience he had acquired.

53. In cross examination Dr Moudgil was taken to a few examples of occasions when he had prescribed Fexofenadine. He agreed that it was difficult to see the rationale for his prescription based on the record made in case 2911 but said that there would have been evidence of sinusitis. Case 448 concerned recorded symptoms of neck pain. Dr Moudgil agreed that case 223 concerned a complaint of spasm in the trapezius muscle for which he had prescribed Fexofenadine. He said that he would have assumed that this complaint related to sinusitis. He also said that he would assume that something had an allergic basis in the absence of allergy testing.

54. We noted that when taken to the graph prepared by Mr Beavon Dr Moudgil said that he thought that this document was partial. He considered that it did not take into account other antihistamines that had been prescribed and that *"it's as if*

someone had tried to narrow me down into an accusation." We consider that the graph is objective evidence and demonstrates the scale of Dr Moudgil's excessive use of Fexofenadine. He also criticized Mr Beavon saying that he had never been asked to explain the rationale for his treatment. When reminded of his conversation with Mr Beavon he said that Mr Beavon had come to accuse him rather than discuss matters with him. We do not accept Dr Moudgil's account in this regard.

55. We acknowledge that Ms Hameer's evidence was that patients had said that Dr Moudgil had mentioned some research. We do not accept Dr Moudgil's evidence that he took meticulous care to explain to patients why he was prescribing Fexofenadine: had he done so it is unlikely that some patients would have approached the pharmacy for an explanation. We accept Mrs Alissa's evidence that she was provided with no real explanation for the prescription. Based on the account Dr Moudgil gave to Dr Alissa and his own evidence, we find that he was endeavouring to conduct some kind of study or research which involved prescribing Fexofenadine based on his personal theory of the aetiology of neck and back pain. We consider it likely the matters concerning the possible relationship with allergy symptoms was grafted on when Dr Moudgil felt challenged by Mr Beavon's enquiries so as to lend some sort of ex post facto justification for his prescription of a drug outside its licensed use.

56. The failure to obtain Ethics Committee approval prior to prescribing a medicine outside its licensed use and in the context of a study or research is a serious matter. It would appear that few if any patients were sufficiently informed so as to gain their true consent in the context of a trial and/or experimental treatment. Moreover, the effect of Dr Moudgil's actions is that many hundreds of Dr Moudgil's patients were not only provided with a wholly inappropriate drug, but were deprived of conventional treatment for the symptoms they presented. In our view Dr Moudgil's use of Fexofenadine and the various rationales that he has given for it were, frankly, bizarre.

The Expert Evidence of the General Practitioners.

57. Dr Corlett prepared reports dated 3rd December 2007 to which Dr Silk responded in his report dated 20th December 2008. Dr Corlett then provided comments on Dr Silk's report in a document dated 13th March 2009. In this she provided an 11 point summary. She also provided a supplementary report dated 23rd April 2009 in which she commented in detail on five cases: 448, 1760, 15364, 20571 and 20715 which were those which had been drawn to Dr Corlett's attention by the Alton Practice. In his comprehensive final report dated 5th May 2009 Dr Silk responded to these as well as those raised by Mr Beavon.

58. We will deal with some of the cases below in more detail but record here the broad nature of the matters where Dr Corlett and Dr Silk agreed because this illuminates nature of the legitimate concerns shared by both GP experts. The experts agreed some cases that concerned the following: inappropriate prescription of blood pressure medication after only one reading; inappropriate prescription of Co-danthramer outside of licensed indications; diagnosis of asthma on the basis of a single attack of wheezing; inappropriate use of Betnesol eye drops; the inappropriate prescription of Fucibet to a child; inappropriate prescribing of antihistamines; suboptimal prescribing of antibiotics; use of drugs of limited clinical value; inadequate record keeping of consultations; inadequate history taking; failure to examine; failure to make urgent referrals; inadequate clinical decision making; wrong diagnosis and prescription; inadequate assessment; inadequate follow up or management plan.

59. We will examine at a later stage some of the main cases where it had appeared that Dr Silk disagreed with Dr Corlett and/or Mr Beavon, and/or where Dr Silk and/or Dr Moudgil sought to put the criticisms against him in context.

60. As a general observation there is some force in Mr Cridland's submission that Dr Corlett did not concede some points that should have been conceded - even if only on the premise of a different factual basis to that which she had assumed based on the records. We have in mind in this regard her evidence concerning an entry that indicated to her that the prescription of cod liver oil had been prescribed for erectile dysfunction. We accept Dr Moudgil's evidence that this was not the case. Her evidence did, however, illustrate the difficulties of another practitioner being able to quickly understand the rationale for some of the treatment prescribed which is an important function of a clinical note.

61. Overall the criticisms made of Dr Corlett's approach did not cause us to doubt the validity of the vast majority of her concerns. The impression we gained is that she is plainly of the school that expects fairly rigid adherence to evidence based medicine and we took this into account in our general assessment. In general the issues she raised were overwhelmingly valid as evidenced by the significant measure of agreement between herself and Dr Silk. Some of the cross examination concerned whether Dr Corlett was applying too high a standard i.e. a so called "gold standard". It was also suggested that the fact that that some care provided by other doctors in the same practice was questionable called into question the impartiality or the validity of Dr Corlett's views since she made no criticism of them. We do not consider that, on proper analysis, either point has any or any significant merit. In our view it is appropriate that we, like general practitioners, should be guided by the principles set out in *"Good Medical Practice for General Practitioners"*. We recognise that departure from this guidance by a general practitioner may be justified on the basis of an informed and considered judgement in an individual case.

62. We considered the evidence in relation to the method by which the cases were selected. We are satisfied that, save in relation to the cases which had been the subject of concern at the practice, the 41 cases were randomly selected and that they are a reasonable representation of Dr Moudgil's practice.

The general prescription issues

63. In his review of a sample of prescriptions issued by Dr Moudgil, Mr Beavon commented also on a number of repeated patterns that fell broadly into the following categories:

    a. failing to prescribe the correct route of administration;

    b. failing to specify the dose at all or the correct dose;

    c. inappropriately using the phrase "as directed" in his prescriptions;

    d. inappropriately making handwritten amendments to computer generated prescriptions.

64. We noted that when asked about many of the individual prescriptions that formed part the broad categorisation a. to d. above, Mr Beavon agreed that, viewed on an individual basis, some of the matters raised were not particularly serious. He was, however, struck by the number involved. In so far as it was said that failures had arisen because of computer problems he was surprised nothing had been done to address the repeated problem. He said that whilst inadvertent errors can occur from time to time that the volume was a matter of concern and the general prescribing pattern was of a lower standard than he

would expect to see in the GP prescribing population. We consider that Mr Beavon was conspicuously fair in his evidence. He also considered it inappropriate to rely on the pharmacist as a second line to pick up routine GP errors because of the risk that an error that had more serious implications might be missed. Dr Corlett agreed with this as did Dr Silk.

The Erythromycin prescriptions.

65. The recommended dose as set out in the BNF of the antibiotic Erythromycin is 250-500 mg every 6 hours or 0.5 -1G every 12 hours. In his statement Mr Beavon commented on the number of occasions that Dr Moudgil had prescribed a sub-therapeutic dose of antibiotics such that the patient would not be effectively treated. He referred to prescriptions 3542, 3326, 3225, 3206, 3195 and 2950 as examples (2/59). In his report of 5th May 2009 Dr Silk accepted Mr Beavon's criticisms regarding these prescriptions and commented that Dr Moudgil made out all the "sub-therapeutic" prescriptions quite deliberately and challenges whether the dose were ineffective (2/117). When dealing with prescriptions that he accepted were potentially significant, he stated "*to these might be added 2998, 3023, 3049 and 2537 which involve alleged but disputed sub-therapeutic doses of antibiotic as compared with the BNF guidelines."* (2/124). We noted also that Dr Silk later commented that Dr Moudgil prescribed Erythromycin three times a day (a total dose of 750mg) deliberately because he was concerned about the side effects of this antibiotic and *"is not convinced that the BNF recommendations are truly evidence based"* (2/120). We noted that in his evidence Dr Moudgil denied that he had made this observation.

66. Dr Moudgil's evidence was that he prescribed in this way with the best of intentions so to avoid for his patients the gastrointestinal side effects associated with Erythromycin. He said that this arose out of his interpretation of the literature. He also said that he had spoken with a consultant pharmacist at St Georges' Hospital and had decided to try a reduced dose and found that this worked. Patients had not returned to him. The tenor of his evidence generally was that he considered the appropriate dose by reference to the individual circumstances of each patient. We noted also that although he agreed that his approach to Erythromycin was idiosyncratic he considered that it was possibly not "wrong-headed." The following day he said that if his approach was considered to be inappropriate he accepted that it should change.

67. The oral evidence of Dr Silk was that although a dose of 750 mg daily could be sub-therapeutic, in many patients it may have a beneficial effect. We consider, however, that this misses the point. The Guidance in the BNF is based on empiric evidence. Whilst it is true to say that the doses prescribed by Dr Moudgil cannot strictly be categorised as sub-therapeutic *in any individual case,* the singular fact is that he did not prescribe in accordance with the BNF recommended dosage and accepted practice. Whilst it may arise that doctor may wish to adjust the dose for good clinical reasons, one would expect this to occur on a case by case basis from time to time. We find that Dr Moudgil prescribed Erythromycin at 750 mgs as a matter of routine. We were not shown any literature that might have led to a misunderstanding on Dr Moudgil's part or that might have justified his approach. We consider that Dr Moudgil's account of his conversation with a consultant pharmacist was somewhat vague and we consider it unlikely that any such advice would have been given or should have been interpreted as a guide to ordinary management in general practice. We consider that if Dr Moudgil had been concerned about potential side effects the obvious solution would have been to prescribe a different antibiotic. Whatever his rationale, his practice reveals a disregard of the conventional evidence based practice and an idiosyncratic approach. We accept the evidence of Dr

Corlett and Mr Beavon that the risk to patient safety is not only that the patient will not receive effective treatment, but that partial antibiotic treatment may cause resistance which has implications for the individual patient and the patient population.

68. We noted that when asked what his approach in future would be Dr Moudgil stated "*If I had to I would stick to the BNF dose".* Even making allowances for the stress of litigation and differences of expression we consider that this indicates that Dr Moudgil did not really accept the considered views of Dr Corlett and Dr Silk.

The Paediatric doses

69. The evidence of Juby Hameer which we have accepted is that Dr Moudgil also prescribed antibiotics for children at a lower dose than is usual. We considered whether this arose because Dr Moudgil genuinely considered that a lower dose was appropriate because the children in question had been premature or whether this was something he said to Ms Hameer to deflect her concerns when he had made a simple mistake. The fact that this occurred on more than one occasion suggests that these dosage issues arose because he thought this was appropriate. We consider that his rationale is somewhat unorthodox given that the children in question (for least two of the prescriptions) were some two years of age. We also consider that Dr Moudgil demonstrated an unwillingness to listen to, reflect on, or value the contribution of a fellow professional in his dealings with Ms Hameer.

The prescription of antibiotics for upper respiratory tract infection.

70. It is well known that general practitioners should guard against the prescription of antibiotics for upper respiratory tract infection. In simple terms such treatment will be ineffective and there is the risk of the development of resistance. We noted that some of the cases cited by Dr Corlett in support of this criticism may have involved prescribing in respect of a lower, rather than upper, respiratory tract infection or tonsillitis or pharyngitis. As an example we find the prescription in case 20741 [3/28] was justified.

71. As to the balance Mr Cridland submitted that Dr Silk did not accept these as "potentially really significant." We note that Dr Silk's opinion was that almost all GPs do prescribe antibiotics for URTIs on occasions and that *some* such prescriptions *may* be appropriate. In our view this general observation falls short of a ringing endorsement of Dr Moudgil's practice. Having examined the evidence in respect of the balance of the cases involved we conclude that the prescriptions are evidence of a tendency to use antibiotics inappropriately. We consider that this is a significant matter.

Cases in which it is said rectal examinations should have been conducted (15364 & 20715)

72. Dr Moudgil's evidence was that both patients refused rectal examinations. When asked why no record was made to this effect in the records Dr Moudgil said that he had been taught not make any negative comment about patients. We consider that it is difficult to see why a simple note indicating that an examination declined in abbreviated form could be negatively construed: it is but a record as to what has happened. Further it is useful information to another doctor seeing the patient thereafter. We consider that the explanation that the patients refused examination had every appearance of being an ex post facto justification for his omissions.

73. We noted that Dr Silk essentially agreed with Dr Corlett's comments that the circumstances in case 15364 called for a rectal examination on 10th January 2005 and that the urgent referral should have been faxed through to the hospital. He also agreed with Dr Corlett's comments concerning case 20175.

74. Mr Cridland submitted that at least so far as this patient 15364 was concerned, it appeared to be the case that a rectal examination would not have altered the management of this patient. Whilst this may be so the fact remains that these (and other cases- see below) indicate a pattern of failure to examine by Dr Moudgil.

Case 20571

75. Dr Corlett's criticism as set out in her report of 23rd April 2009 (2/95) was that in the light of this patient's history Dr Moudgil should have performed a vaginal examination (hereafter "VE") at least before he referred her to the gynaecology department. Had he done so he should have been able to identify the abdominal mass, and thus, the cause for the patient's anaemia. She also considered that it was unnecessary for Dr Moudgil to have also referred the patient to the Haematology department. She also noted that when referring to the gynaecologist Dr Moudgil stated that the patient was suffering from bleeding per rectum when, in fact, the complaint was that of heavy periods.

76. Mr Cridland submitted that the suggestion that referral should have been made sooner in this case was a new criticism. We consider that this rather overlooks that this was the very conclusion reached by Dr Silk when he agreed with Dr Corlett's comments and said Dr Moudgil should have made greater efforts to ensure that the patient was seen in hospital within 10 days or so (2/125). Mr Cridland also submitted that it also difficult to understand the criticism given that:

- Dr Moudgil attempted to contact the patient by phone and then in writing in order to give the patient her blood test results and refer her to hospital
- On 8th September 2006 Dr Moudgil referred the patient to the gynaecologists and haematologists [3/257 - 258].
- The patient refused the advice of the hospital doctors given on 22nd September 2006 that she should be admitted that day
- When next seen by Dr Moudgil on 10th October 2006 he made a further referral to the hospital gynaecologists which the patient again defaulted on.

77. We note that, having considered Dr Moudgil's difficulties as set out above, Dr Silk nonetheless considered that this situation was pressing. We agree that Dr Moudgil did make efforts to ensure that the patient was seen in hospital. The gravamen of Dr Corlett's criticism was that vaginal examination would have informed the issue and nature of the referral. We consider that the efforts made by Dr Moudgil with regard to referral to two different specialists were dysfunctional. The fact that the patient refused later admission to hospital and/or defaulted on appointments thereafter does not, in our view, provide any logical reason for failing to deal with her care in a coordinated manner in the first place.

Case 448.

78. This case concerned a patient treated by Dr Moudgil who was ultimately diagnosed with metastatic colorectal cancer.

79. On 17th May 2006 the patient gave a history of neck pain for three days. He was prescribed Fexofenadine. Blood tests were ordered and the results showed a Haemoglobin result of 9.6 and a low MCV and MVH. When the patient returned on 31st May 2006 it was recorded that he had lost a stone in three months. He was referred for urgent ultrasound. He was prescribed omeprazole and ferrous gluconate and a note was made concerning referral to the gastroenterology department. The results of ultrasound revealed multiple liver metastases. On 7th June 2006 Dr Moudgil referred the patient to an urologist, a gastroenterologist and to the radiology department. The referral letter to both the urologist and the gastroenterologist requested that the patient be seen within the two week rule and referred to symptoms of pallor and weight loss. No reference was made in the referral letter to anaemia.

80. Dr Moudgil's evidence was that he made prompt and reasonable efforts to narrow the differential diagnosis and refer appropriately.

81. Dr Corlett's opinion was that the FBC results should have precipitated an urgent referral in accordance with the NICE cancer referral guidelines because the patient's iron deficiency anaemia was a *"red alert symptom"* for gastro intestinal problems warranting urgent investigation. On 31st May 2006 the history of weight loss should also have precipitated a two week referral for investigation of suspected gastrointestinal cancer. It was inappropriate for Dr Moudgil to await the results of ultrasound. It was illogical to refer to the urology department when the ultrasound results were available because his symptoms did not suggest urological cancer.

82. Dr Silk referred to the NICE guidelines and noted the definition of "unexplained" anaemia. He considered that the delay in urgent referral was justified in order to evaluate the case although he considered that Dr Moudgil *"might have been better"* making an urgent referral after he became aware of the patient's loss of weight. His essential point was that it was reasonable to try and clarify the various signs and symptoms including the anaemia before making a referral.

83. Having carefully considered all the points made by Dr Silk in his report (2/127) we noted that the patient's symptoms were gastrointestinal. We agree with Dr Corlett's assessment that this case demonstrated a failure to make an adequate diagnostic assessment or to prioritise the patient's symptoms. We acknowledge that earlier referral would not have made any difference to the outcome but consider this case illustrates a lack of logical prioritisation.

The prescription of Azithromycin for 12 days (prescription 2534)

84. Dr Silk considered that this was a "potentially really significant" criticism. The normal dose of Azithromycin in the circumstances that arose is 250mg twice daily for three days. Dr Moudgil's explanation was he was aware of practice at the Brompton Hospital to treat patients with Azithromycin for a period of up to 2 – 3 weeks and that he felt in relation to this particular patient there was a need for relatively aggressive treatment. We refer to paragraph 30 of Dr Moudgil's second witness statement [(2/139]. Mr Cridland submitted that although Dr Moudgil had been doing his best for this particular patient, he indicated in his evidence that he was receptive to the comments of both Doctors Corlett and Silk.

85. We considered Dr Moudgil's evidence in relation to the issue of insight. He said that it was simplistic to go by the recommended dose in the BNF and that he

had to be honest with his patients: this involved crossing the boundaries but this had not happened on a whim as he had seen longer course prescribed in other settings. He also said that he had applied the experience he had: if Dr Corlett did not wish him to use his experience and wanted him to stay "blinkered" he would accept that he was wrong. From this and other answers in like vein, we formed the clear impression from Dr Moudgil's evidence that he felt driven to defer to his colleagues rather than that he truly could see why the prescription was inappropriate. Dr Moudgil said that he acted as he did so that the patient would have adequate treatment over the Christmas holiday. The date of the consultation was 18th December which on any basis gave adequate time for appropriate first line treatment to be given for three days and reviewed as necessary.

The prescription of Sibutramine to a patient (prescriptions 522 and 10494)

86. It is common ground that patients should not be prescribed Sibutramine (an aid to weight loss) unless weight, blood pressure and pulse are recorded and thereafter monitored.

87. In case 522 Sibutramine was prescribed under Dr Moudgil's name but there is no indication that any monitoring checks were made. Dr Moudgil denies that he was the prescriber. Dr. Silk's evidence was that he had not personally come across a case in which the EMIS system recorded the wrong GP as prescriber. We noted, however, there appeared to be evidence of an entry being made in Dr Moudgil's name at a time when he was suspended. Further the drug Ezitembe was also prescribed at the same consultation of 5th October 2004 and Dr Moudgil said this was not a drug he had ever prescribed. Additionally we noted that Patient 10494 was commenced on a monitoring of weight loss, blood pressure and pulse by Dr Moudgil albeit that this was not performed thereafter at the required frequency. We noted that this disputed prescription was the sole occasion that Dr Moudgil claimed that he was not the prescriber. In light of all these factors we are not satisfied on balance that this prescription was issued by Dr Moudgil.

88. So far as case 10494 [3/38] is concerned, Dr Moudgil agrees he was the prescribing and treating GP but says that the consultations which contain no record of the taking of blood pressure and pulse readings are the result of a failure in the EMIS system. We consider it unlikely that a computer error would have occurred on more than one occasion in respect to the records of one patient and conclude that Dr Moudgil did not monitor the patient as he should have done. We regard the failure to perform monitoring checks as a significant criticism given the nature of the drug involved and the potential complications that can arise

The Thyroxine case (13778).

89. The criticism is that Dr Moudgil inappropriately prescribed drugs for a chronic condition without justification because, in this case, the patient's TSH was normal. Dr Silk agrees with the criticism [2/106]. Dr Moudgil's evidence was that he placed the patient for a trial period on the drug based on the patient's history of previous radiotherapy and clinical presentation. We consider that this was a tenuous basis to commence treatment with Thyroxine given the potential implications concerning long term treatment with this drug. Dr Moudgil suggested that this prescription was for a trial period but we note that no record was made by Dr Moudgil with regard to the need to review the benefit of this unusual prescription. We noted that despite Dr Silk's agreement that this treatment was not justified in the absence of an abnormal TSH, Dr Moudgil effectively maintained that his treatment was appropriate because of what he

had learnt from a consultant radiologist in a hospital setting. He also relied on a subsequent note in 2007 which indicated that the patient's condition had improved. We consider Dr Moudgil demonstrated in his answers that he does not really accept that Dr Corlett and Dr Silk are right: this is matter of concern when assessing his insight.

The Gynaecology cases (9952 and 4740).

90. Dr Corlett criticizes Dr Moudgil for not undertaking gynaecological examinations in these cases.

91. **Case 9952** concerned a lady who was referred by Dr Moudgil to a consultant gynaecologist by letter dated 17th March 2003. The referral letter related that the patient had a felt a bearing sensation and a feeling of mass in the vagina during the day and whilst passing motions. It also stated that the patient had post menopausal bleeding ("PMB"). On the same date Dr Moudgil also made referral to a consultant surgeon because of the patient's increasing history of constipation and one or two recent episodes of bleeding per rectum and requested an urgent appointment. The letter related a family history of cancer.

92. The thrust of Dr Corlett's criticism was a vaginal examination ("VE") should have been performed by Dr Moudgil because post menopausal bleeding is a "red flag symptom" so examination was mandatory. If, after a VE, gynaecological referral was warranted it should have been made on an urgent basis. Dr Silk referred to cancer referral guidelines in 2004 that recommend referral for heavy post menopausal bleeding. Further, light spotting in a post menopausal woman not on HRT justifies an early referral within 4-6 weeks.

93. In cross-examination, Dr Moudgil asserted that the patient had never had post menopausal bleeding but that he had included this symptom so as to facilitate the referral because the patient insisted on referral to a gynaecologist. He described his position as being that of a *"sitting duck"*. He said that the patient's right to request referral was paramount and that if the patient wanted to see a gynaecologist he, as GP, had to agree. He then went on to say that he had selected PMB as this was the only code that the computer permitted. When this was explored he reverted to his explanation that his entry was engineered so as to make a case for the patient to be seen.

94. We do not accept Dr Moudgil's account. We find that the likelihood is that this patient did have post menopausal bleeding. It is implicit from Dr Silk's observations that a better history should have been elicited. A vaginal examination should have been performed and, dependant on the result of the examination, she should have been urgently referred to a gynaecologist.

95. **Case 4740** related to a patient who attended Dr Moudgil on 19th February 2004 complaining of pain in the right lower abdomen and bleeding per vagina since a termination of pregnancy on 9th February. Dr Moudgil undertook a urine test and referred the patient to A&E. It is not clear whether the patient ever attended A&E although it is known that a scan was reported on 23rd February 2004 which related that there was no evidence of retained products of conception.

96. The main thrust of Dr Corlett's criticism was that a vaginal examination should have been undertaken before referral was made. Dr Silk was "not convinced" that a VE was mandatory. Dr Moudgil said in evidence that he did not do so because it would have caused trauma to the patient and an examination may have dislodged a clot holding back a large haemorrhage. When challenged as to why he referred to the A&E Dr Moudgil said that an ambulance was called as the patient was bleeding.

97. We noted that there is no indication in the records that an ambulance was called and that no reference was made to this in Dr Moudgil's statement where he simply stated that a VE *"would only have served to delay the patient's access to specialist care."* We do not regard this as a logical or sufficient reason to fail to perform a VE as this would not cause any undue delay. We consider it unlikely that an ambulance was called because there is no record to this effect.

98. We noted that in the many records of female patients before us there is no record of Dr Moudgil ever having undertaken a VE (or having arranged for a VE to be performed by a female doctor) in the primary care setting. We consider it unlikely that any of the reasons put forward by Dr Moudgil reflect the real reason that he did not perform a VE on this occasion. We accept Dr Corlett's evidence that it would have been good practice had a VE been performed. On the basis that the patient was being sent to hospital that day we do not, however, find that the failure to perform a VE on this particular occasion merits serious criticism.

99. We agree, however, with Dr Corlett's secondary criticism that it would have been appropriate had Dr Moudgil referred the patient direct to the gynaecology clinic rather than A&E. We noted that Dr Silk said that this would have been best practice (2/116). In our view it would have been entirely logical to do so in order to avoid unnecessary delay. We consider that Dr Moudgil's evidence about an ambulance being called was an ex post facto explanation designed to overcome this criticism because an ambulance would normally admit via A&E.

The known diabetic patient previously on insulin (21970)

100. On 31st July 2006 Dr Moudgil noted that this patient was a known diabetic who had been on insulin until six weeks previously. He requested a blood sugar result and the investigation result was recorded against an entry 1st August as "grossly haemolysed". On 7th August 2008 Dr Moudgil saw the patient and recorded "blood sugar normal but –diabetic control 8.7% HbA1C..."

101. Dr Moudgil's case is that the result was not available and so he telephoned the laboratory told him that the HBA1C level was 8.7% and the blood sugar result was normal. He accepted that he should have asked for the actual result rather than contenting himself with the description "normal". Dr Moudgil said in his statement that he arranged for the patient to be seen at a diabetic clinic at Queen Mary's Hospital and wrote a handwritten referral.

102. We noted the evidence that serum glucose results are usually available within a day or so of the testing. We consider it unlikely that a laboratory technician would have referred to a grossly haemolysed sample as normal. We do not accept Dr Moudgil's account as to what occurred: the probabilities are that the entry on 7th August reflected his own error. We do not accept that he made a referral on 7th August because he made no reference to this in his notes. When cross examined on this he said that he had spoken to a diabetologist who had agreed to see the patient the next week. We find that he merely prescribed a urine kit and chart.

103. On 15th August 2006 the patient was seen by Dr Alissa who referred her urgently to Kingston Hospital. On a simple urine test he noted "++++glucose..." and made an urgent referral to Kingston Hospital where the patient was admitted that day. The Discharge Notification summary relates that the patient presented with "...polyuria, polydipsia, weak, generally unwell...known diabetic usually on Mixtard 30. Ran out of insulin 1 month ago. Saw GP but "given form for blood" and not given insulin..." The patient was treated with insulin and spent six days in hospital.

104. Having seen and heard Dr Moudgil give evidence on this issue we consider that the likelihood is that he had no real understanding of the risks that presented with this patient on 31st July or 7th August. The manner in which he dealt with her care was inadequate because he failed to take a sufficient history and failed to prescribe insulin.

The Prednisolone cases

105. In these cases Dr Moudgil prescribed a steroid (prednisolone) without a clear indication of the treatment length being recorded in the records. We agree with Dr Corlett's evidence that the number of tablets prescribed were indicative of lengthy courses. The debate centred on whether it was adequate to provide the patient with a piece of paper setting out the tapering dose. In cross-examination, Dr Silk said that he adopted a similar practice but that he made a brief record in the notes to indicate that a reducing regime had been advised. Dr Silk said that he would reconsider his own practice in this regard. In our view there could be no criticism of a GP who provides a post-it note for the patient's information provided he also records in sufficient detail in the patient's records for another doctor to know the regime that has been prescribed. Dr Moudgil's explanation was that he did not record or retain any record because he found that it was time consuming and/or because he had difficulty in mastering the computer for this purpose. We do not consider that his practice in failing to keep a record of what he had prescribed is acceptable for the obvious reason that such a record is necessary so as to enable continuity of care.

The Unsuitability Ground

106. Mr Cridland submitted that the ground of "unsuitability" could not apply in this case for the following reasons:

(1) The concept of unsuitability should be interpreted ejusdem generis to the criteria at paragraph 11(2) of the 2004 Regulations.

(2) The various criteria at 11(2) strongly suggest that "unsuitability" is concerned with cases involving serious misconduct or criminal behaviour on the part of the Performer.

(3) To the extent that the concept of unsuitability may extend to encompassing and including within it cases involving deep seated attitudinal problems or personality disorder, those, it seems clear from paragraph 11(2), need to result in misconduct or criminal behaviour.

(4) In any event, there is no evidence in this case that Dr Moudgil has such deep seated attitudinal problems or personality disorder.

We turn to consider the Regulations.

The National Health Service (Performers List) Regulations 2004

107. Regulation 11 sets out the criteria for removal in relation to unsuitability, fraud and efficiency.

108. Regulation 11(1) of the 2004 Regulations (unsuitability) provides that in addition to the matters specified therein the PCT shall in reaching its decision, "take into consideration the matters set out in paragraph (2) which list the matters as follows:

(a) *the nature of any offence, investigation or incident;*

(b) *the length of the time since any such offence, incident, conviction or investigation:*

(c) *any action taken or penalty imposed by any licensing, regulatory or other body, the police or the courts as a result of any such offence, incident or investigation;*

(d) *The relevance of any offence, incident or investigation to his performing relevant primary services and any likely risk to patients or to public finances;*

(e) *whether any offence was a sexual offence ...*

(f) *whether he has previously failed to supply information, make a declaration or comply with an undertaking required on inclusion in a list;*

(g) *whether the performer has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or the equivalent body for such action;...*

109. Under Regulation 11(5) and (6) the matters to be considered when considering removal on efficiency grounds are as follows:

a. *The nature of any incident which was prejudicial to the efficiency of the services, which the performer performed;*

b. *the length of the time since the last incident occurred and since any investigation into it was concluded;*

c. *any action taken by any licensing, regulatory or other body, the police or the courts as a result of any such incident;*

d. *the nature of the incident and whether there is a likely risk to patients;*

e. *whether the performer has ever failed to comply with a request to undertake an assessment by the NPSA;*

f. *whether he has previously failed to supply information, make a declaration or comply with an undertaking required on inclusion in a list;*

g. *whether he has been refused admittance to, conditionally included in, removed or contingently removed or is currently suspended from any list or equivalent list, and if so, the facts relating to the matter which led to such action and the reasons given by the Primary Care Trust or the equivalent body for such action;...*

110. We do not consider that the reference to “any offence, investigation or incident” even when read in the context of the rest of regulation 11 means that only misconduct or criminal behaviour is capable of satisfying the grounds of “unsuitability”. Regulation 11 (2) itself does not purport to define the grounds for unsuitability. It simply lists the matters that shall be taken into consideration when removal is being considered on this ground. There is no reference to

"misconduct" in the regulation 11(2) although we recognise, with reference to regulation 11(2)(c) that the action taken by a regulatory body (such as the General Medical Council) in relation to fitness to practice may be based on allegations of "misconduct". However, such action could also have been based on "deficient professional performance" or even "adverse physical or mental health" (see section 35C of the Medical Act 1983 as amended). In our view there is no reason why the word misconduct should be read into the regulations as a limitation. Amongst other things the purpose of regulation 11(2) is to ensure that PCT decisions are not taken in ignorance of other relevant offences, incidents or investigations or any action taken or not taken by any other PCTs or any regulatory body (such as the GMC) or the police. The word that is common to both regulation 11(2) and (6) is that of "incident". We consider that the word "incident" is to be construed in its ordinary meaning. In our view any incident could be the subject of unsuitability grounds even if it also provides a basis for considering removal on the basis of inefficiency.

111. We noted also that paragraph 11(7) which governs any decision to remove irrespective of the ground relied on, requires the PCT to take into account *"the overall effect of any relevant incidents and offences relating to the performer of which it is aware, whichever condition it relies on."* We consider that the bright or hard edged line for which the Appellant contends does not exist and that "unsuitability" is to be considered using its ordinary meaning and in overall context.

112. Our interpretation of the regulations is reinforced by the guidance provided by the Department of Health in *"Delivery Quality in Primary Care"* states that the unsuitability ground may be used where *"there is a lack of tangible evidence of a doctor's ability to undertake the required role (for example, satisfactory qualifications and experience, essential qualities)* and further that *"the term is used in its everyday meaning and so provides PCTs with a broad area of discretion. Suitability and efficiency grounds may overlap and in many cases a PCT may find itself able to take action against a doctor on either ground."*

Our conclusion in respect of "unsuitability"

113. In our view the issue is whether the overall effect of our findings, taking into account the matters set out in paragraph 11(2) of the Regulations, is such that it should lead us to reach the view that Dr Moudgil is unsuitable to be a primary care performer of services on the Respondent's list. It was agreed that this is a matter of judgement rather than an issue of fact (*see GMC v Biswas*). Mr Cridland agreed that if Dr Moudgil is truly unsuitable the issue of removal contingent upon his compliance with conditions does not arise as a matter of law: there is no power to direct contingent removal in an unsuitability case. The power to remove on unsuitability grounds is, however, discretionary and must be informed by consideration of the matters set out in Regulation 11 (1) and (2) and (7) as well as the principle of proportionality.

114. We consider that the inadequacies in Dr Moudgil's practice were wide ranging and go to the very core of the skills and attributes required of a general practitioner. We consider that it is likely that the deficiencies that were the subject of essential agreement between the experts were replicated in the rest of Dr Moudgil's practice. We noted also that on the agreed evidence before us there was evidence of unacceptable practice on multiple issues and occasions in relation to very many of the patients whose records were considered. We bear in mind that Dr Moudgil believed that he was doing his best for his patients. The fact is that in very material respects his practice was fundamentally flawed and was contrary to conventional evidence based practice. We are satisfied that

the incidents on which the hearing focussed were not isolated errors or failings, or even errors arising in some areas in which he had less confidence, but were systemic in his general practice. These were not failures that arose because Dr Moudgil had become de-skilled or out of date with the standards of ordinary practice but rather ones where Dr Moudgil firmly pursued his own instincts and beliefs without regard to accepted standards of practice or an evidence based approach. Specifically in relation to Fexofenadine and the paediatric doses of antibiotics he rebuffed the approach of fellow professionals such as Ms Hameer. He sought to deflect inquiry by Mr Beavon and Ms Hameer by a degree of confabulation and/or bluff. In so doing he demonstrated that he is not someone who, by nature, is open to the notion that he may be called on to explain his treatment approach or to listen or learn from the viewpoints of others.

115. It is true to say that the art of medicine is such that there is room for differing schools of thought, and, indeed, that some treatments which are now accepted practice were originally considered unconventional. However, any treatment prescribed still has to be capable of being justified on rational grounds. There was a lack of coherence or logic in Dr Moudgil's explanations for his practice which leads us to conclude that the suggestion that he holds idiosyncratic and illogical views is well founded.

116. We noted that Dr Moudgil has in these proceedings admitted the vast majority of the matters alleged and had said that he would hereafter defer to the opinion of distinguished colleagues. We noted that Dr Silk considered that Dr Moudgil had insight and was willing to learn. We came to the view that his true character and disposition is such that in any real life situation he would find this extremely difficult, if not impossible. We have already noted some of the many instances where in his evidence Dr Moudgil demonstrated his lack of insight. Having seen and heard him give evidence over a period of two days and having considered all his evidence in detail, we formed the clear view that beneath the veil of his claimed insight lay a deeply entrenched attitude and resistance to true self reflection and change. We consider that the admissions that he made were driven by the exigencies of the litigation rather than genuine reflection. In our view he lacks the attributes of true insight and self reflection. His approach to practice is due to deep-seated and irremediable personality characteristics as well as a lack of coherent and logical analysis.

117. We consider that Dr Moudgil's practice poses a clear risk to the public interest. The particular risks engaged are those of patient safety and well being as well as the maintenance of confidence in the ability of those who perform NHS primary services to provide a safe and appropriate service and in the NHS itself.

118. We were mindful of the long service that Dr Moudgil has provided over his years in the NHS. As noted above he became a general practitioner after many years in NHS Hospital Service. There is no evidence that there had ever been any difficulties in his early years in general practice before joining the Alton practice. We note that he came to the Alton practice with good references. We accept the evidence that problems became apparent within about a year or so of his arrival. We are mindful that some time has elapsed since the last incident. Dr Moudgil has been unable to practice as a NHS practitioner because of the interim suspension order made by the PCT. He has also been unable to practice as a registered medical practitioner by reason of the interim order of the GMC on 14th June 2007 pending its own consideration of Dr Moudgil's fitness to practice.

119. By reason of the evidence placed before us in our preliminary hearing we are generally aware of the circumstances of Dr Moudgil's private and family life. It is inappropriate to recite personal details herein but we have taken them fully into account. Plainly any decision to remove Dr Moudgil will have very profound effects his ability to earn his living in his chosen profession and upon his personal and family life.

120. We have considered all the factors set out in Regulation 11(1) and (2) and have considered the overall effect of the matters before us. Having balanced the effect of any decision upon the Appellant against the risks to patient safety and the public interest in the National Health Service we consider that it is reasonable, necessary and proportionate to direct that Dr Moudgil's name is removed from the list maintained by the Respondent.

Efficiency considered in the alternative.

121. Given our conclusions in relation to the unsuitability grounds it is unnecessary to consider inefficiency and the imposition of contingent removal. However, lest we are wrong in our conclusion that the unsuitability grounds do not require that the "incidents" be in the nature of misconduct or criminal in nature, we have considered the appeal on the basis of inefficiency. Whilst this may seem somewhat circular given that the same incidents form the basis of the alternative grounds, it is necessary to do so: if our conclusion in relation to meaning of "unsuitability" is wrong, the issue of whether the inefficiency can be adequately addressed by the imposition of conditions would arise.

122. We start from the premise that (absent removal on the grounds of unsuitability) proportionality requires that if appropriate conditions can be devised that will provide adequate or sufficient protection to patients and the public interest that is the course that should be adopted. Having seen and heard Dr Moudgil we consider it very unlikely that the habits that he has acquired would be eradicated by any period of training even if the training were to be judged to have been successful. Thus it would be necessary to impose a condition in relation to supervised practice. By its very nature the Appellant's propensity to idiosyncrasy and lack of logicality would be extremely hard to monitor by way of supervision unless every single consultation, prescription or decision in the realm of diagnosis and treatment were to be overseen by another doctor. This is neither feasible nor realistic. We do not consider that the fact that Dr Moudgil ceased to prescribe Fexofenadine after Mr Middleton's letter provides any reliable indication that Dr Moudgil would be able to eradicate his propensity towards idiosyncrasy in his approach to general practice. His approach to the prescription of Erythromycin, Azithromycin and Thyroxine and some paediatric doses of antibiotics was also idiosyncratic. Further in very many areas across the breadth of his practice his approach was contrary to appropriate standards as set out on Good Medical Practice. Whatever training or supervision were to be put in place, we consider it very likely that Dr Moudgil's singular approach would again emerge. In our judgement his approach to practice is due to deep-seated and irremediable characteristics – hence our conclusion in respect of suitability. We consider that his continued practice, even if subject to retraining or other conditions such as supervision, poses a clear risk to patient safety and the public interest in the efficiency in primary care services in the NHS.

Conclusion

123. We conclude that Dr Moudgil is unsuitable to be included in the Respondent's list. We have considered all of the relevant matters under paragraph 11 of the regulations. Having balanced the effects of removal upon his personal, family and professional life we have decided that it is necessary that that Dr Moudgil's name be removed from the Respondent's list on the grounds of unsuitability.

124. Lest our conclusion in relation to the meaning of unsuitability is wrong as a matter of law, we have considered the issue of disposal on the basis of the Appellant's admitted inefficiency. Having balanced the risks to the patients and the public interest against the Appellant's own interests, we consider that removal is the necessary and proportionate response under this alternative ground.

THE DECISION

125. The appeal is dismissed. We direct that the Appellant's name is removed from the performers list of the Respondent PCT under paragraph 10 (4) (c) of the Regulations on the grounds that the Appellant is unsuitable to be included therein.

126. Pursuant to paragraph 16 (2) of the Regulations and Rule 46 and 47(1) of the Family Health Services Appeal Authority (Procedure) Rules 2001 we direct that the Registrar of the General Medical Council shall be notified of this decision.

127. The attention of the parties is drawn to Rule 43 of the Rules.

128. Either 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. Any appeal should 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.

National Disqualification

129. We did not hear submissions on this potential order pending our decision. We now direct:

i. The parties shall submit written representations on the issue of national disqualification within 35 days of receipt of this decision.
ii. If the parties so require, an oral hearing will be held on a date to be agreed.
iii. Both parties are directed to inform the FHSAA within 42 days from receipt of this decision whether they seek an oral hearing of this issue.

Siobhan Goodrich
Chair
16th October 2009