PUBLIC RECORD

Dates: 07/07/2025 - 09/07/2025

Doctor:	Dr Om ARORA
GMC reference number:	2445320
Primary medical qualification:	MB BS 1971 Punjabi University

Type of case
Restoration following disciplinary erasure

Summary of outcome
Restoration application refused. No further applications allowed for 12 months from last application.

Tribunal:

Legally Qualified Chair	Mrs Aaminah Khan
Lay Tribunal Member:	Mr George McLean
Registrant Tribunal Member:	Dr Charlotte Jones

Tribunal Clerk:	Mr Matt O'Reilly

Attendance and Representation:

Doctor:	Present, not represented
GMC Representative:	Ms Harriet Dixon, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Restoration - 09/07/2025

1. The Tribunal has convened to consider Dr Arora's application for his name to be restored to the medical register following his erasure for disciplinary reasons in June 2011.

2. The Tribunal has considered the application in accordance with Section 41 of the Medical Act 1983, as amended ('the Act') and Rule 24 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules').

3. This is Dr Arora's first application to be restored to the medical register.

Background

4. In August 2003 the GMC was notified by the Medical Director of Birmingham Heartlands Hospital of concerns about the standard of Dr Arora's professional performance. In light of these concerns, Dr Arora agreed to undergo an assessment of the standard of his professional performance. The assessment took place in May 2004 and the findings of the assessment team indicated that the standard of Dr Arora's professional performance was unacceptable in the following areas:

- Assessment of the patient's condition.
- Providing or arranging investigations.
- Providing or arranging treatment.
- Record keeping.
- Treatment in emergencies.
- Constructive participation in audit, assessment and appraisal.
- Communication with patients.

5. The assessment team also found that Dr Arora's performance was a cause for concern in the following areas:

- Working within limits of competence.
- Paying due regard to efficacy and use of resources.
- Respect for patients, trust and confidentiality.
- Relationships with colleagues/GPs/teamwork.

6. Phase two of the performance assessment consisted of a knowledge test in the form of extended matching questions (EMQs), a simulated surgery of ten scenarios, and a 13-station objective structured clinical examination (OSCE). Dr Arora's score in the knowledge test was 50%, which was below the minimum acceptable score of 68%. Dr Arora's score in the simulated surgeries was 44%, which was below the minimum acceptable score of 50%. His score of 74% in the OSCEs was above the minimum acceptable score of 70%. As a consequence, Dr Arora's case was referred to a Fitness to Practise Panel and a hearing was held between 13-16 March 2006 ('the 2006 Panel').

7. In his evidence before the 2006 Panel, the Lead Assessor conceded in evidence that Dr Arora's communication with patients could be categorised as a cause for concern as opposed to unacceptable. The 2006 Panel noted that Dr Arora stated that the assessment process was triggered by unrealistic expectations of the Genito-urinary team at Hawthorn House, Birmingham Heartlands Hospital. Further, Dr Arora said that he was there to learn in his capacity as a part-time clinical assistant, yet the team expected him to be taking clinics on his own shortly after he commenced work there. The 2006 Panel also considered Dr Arora's comments that most of the third-party interviews in the assessment were with people who had not previously raised any concerns with him or had not seen him working. The 2006 Panel considered however that Dr Arora had been given notice several times in communications with the GMC performance assessment officer that a separate list of nominated interviewees should be forwarded by him prior to the commencement of the assessment. It also concluded that, although it had sympathy for Dr Arora's view that he was expected to work unsupervised in a part-time clinical assistant post at the Genito-urinary clinic, a reasonably competent practitioner could have met the demands of the post and that the concerns raised regarding his performance were valid.

8. The 2006 Panel noted Dr Arora's submission that he was unfamiliar with the format of the questions in the phase two knowledge test and that he would have done better if given more time. The 2008 Panel accepted that whilst Genito-urinary medicine was the area of practice that prompted initial concerns, this was an unfamiliar area of medicine and that he had worked as a GP and in Ophthalmology without complaint for many years. However, the

2006 Panel considered that Dr Arora had not grasped the gravity of the concerns raised, in particular his own submission that he did not consider it necessary to be fully equipped or be prepared to deal with emergency situations. It considered that the deficiencies highlighted were serious, wide-ranging and that Dr Arora's performance fell below the standard to be expected of a qualified doctor practising medicine. The 2006 Panel determined that Dr Arora's fitness to practise was impaired and it imposed a period of conditional registration for 18 months.

9. Dr Arora appealed the decision of the 2006 Panel with the High Court, but subsequently withdrew his appeal and the conditions that had been imposed therefore took effect in July 2007.

10. Dr Arora's case was reviewed between 14-24 January 2008 ('the January 2008 Panel'). The January 2008 Panel noted that one of the conditions imposed on Dr Arora's registration was that he must complete and pass all three components of the phase two assessment. A repeat phase two performance assessment was subsequently carried out in November 2007 when, in the single best answer (SBA) questions, Dr Arora scored 31% which was well below the minimum acceptable score of 64.85%. In the EMQ questions, Dr Arora scored 51% which was well below the minimum acceptable scores of 73.27%. However, in the simulated surgery, Dr Arora scored 60.63%, which was above the minimum acceptable score of 50%. In the OCSE he scored 75%, which was above the minimum acceptable score of 70%.

11. The report of the assessment team concluded that Dr Arora had managed to improve his performance in the test of competence between 2004 and 2007, but still had an unacceptable level of knowledge. The assessment team considered that Dr Arora's situation was remediable, particularly taking into account that he had managed to improve his performance in the simulated surgery. It considered that Dr Arora required a period of supervised training and study to bring his knowledge up to an acceptable level. The January 2008 Panel therefore determined that Dr Arora's fitness to practise remained impaired by reason of his deficient professional performance. It also determined that Dr Arora had failed to comply with the condition requiring him to submit his Personal Development Plan (PDP) to the GMC in good time.

12. The January 2008 Panel also enquired into new allegations against Dr Arora of deficient professional performance relating to his ophthalmic practice. It noted that in April 2006, Dr Arora conducted sight tests on two patients while being observed by a Dr C, an optometrist who had been invited for that purpose by the Primary Care Trust. Dr C also assessed Dr Arora's knowledge of current accepted primary care ophthalmic practice, focusing on four eye care pathways. Dr C concluded that Dr Arora's practice was unsafe.

13. The January 2008 Panel also determined that Dr Arora's actions in relation to each of these patients were inaccurate, inappropriate and below the standards to be expected of a reasonably competent registered medical practitioner delivering ophthalmic services. The 2008 Panel concluded that Dr Arora's fitness to practise was also impaired for these reasons. A finding of dishonesty was also made in respect of Dr Arora working as a GP when not on the Performers List.

14. Dr Arora successfully appealed that decision in the High Court and the finding of dishonesty was quashed. As a result, the matter was remitted back to a Fitness to Practise Panel for reconsideration in respect of the finding of impairment by reason of misconduct. This was considered between by an MPT between 7-9 July 2008 ('the July 2008 Panel').

15. The July 2008 Panel concluded that Dr Arora's fitness to practise was not impaired by reason of misconduct, and instead issued a warning in respect of Dr Arora's representing that he was on the Wandsworth PCT performance list, when in fact he was not. When considering sanction for the finding of impairment by reason of deficient professional performance, the July 2008 Panel indicated that whilst it was very concerned about the evidence of deficiency in Dr Arora's factual knowledge, there was scope for remedial action. It noted that Dr Arora had attempted to keep his medical knowledge up to date through attendance at courses and continuing professional development, but observed that there was still more to be done, particularly in relation to improving his core knowledge and skills. The July 2008 Panel was satisfied that Dr Arora had the potential and willingness to retrain and take remedial action. They also stressed that Dr Arora would need to focus on General Practice and not stray into other areas of medicine as he had done in the past. The July 2008 Panel determined to impose conditions on Dr Arora's registration for a period of 18 months. The conditions limited the roles in which Dr Arora could work, required him to have a workplace supervisor and mentor and to pass the phase two assessment in its entirety.

16. Dr Arora undertook two London Deanery return to practice assessments in early 2009, both of which he failed. The Tribunal did not have those assessments before it though some reference to them was made by the subsequent reviewing Panel in 2009 as having occurred that year.

17. Dr Arora requested an early review of his case as he was unable to secure a placement in General Practice. The early review took place between 9-10 November 2009 ('The 2009 Panel'). That Panel concluded that Dr Arora's failure to produce a revised PDP and to forward it to the GMC was a breach of conditions 11 and 13. However, the 2009 Panel acknowledged that Dr Arora had made some efforts to retrain, and that the steps he had

taken demonstrated some insight into his failings. The 2009 Panel was satisfied that Dr Arora had the potential and willingness to retrain and take remedial action. It determined to impose conditions on his registration for a period of 18 months. The 2009 Panel was satisfied that, notwithstanding the breach of conditions, Dr Arora fully understood the importance of complying with the reasonable requests of the GMC and that he would abide by conditions. It also directed that a review take place and a reviewing panel may be assisted by:

- Documentary evidence that Dr Arora had complied with the conditions imposed on his registration.
- A copy of Dr Arora's Personal Development Plan, even if he had been unable to obtain a placement in any field of medical practice.
- Documentary evidence of the steps taken to address the deficiencies in his practice, including improving his core knowledge skills.
- Reports from Dr Arora's workplace and educational supervisor on his progress.
- Reports from the Postgraduate Dean or Director of Postgraduate General Practice Education or their deputies, on Dr Arora's progress.
- Report of the assessment team following Dr Arora undertaking phase two of the performance assessment.
- The record of the meetings with Dr Arora has with his educational supervisor.

18. Dr Arora's case was reviewed between 31 May-2 June 2011 ('the 2011 Panel'). The 2011 Panel noted that the assessment team carried out a repeat competence assessment in October 2010 and were instructed to assess Dr Arora at a training level rather than specialist grade and to assess across a general medical portfolio, as would be expected of a recent graduate at the beginning of career training. The assessment team were also instructed to be mindful of Dr Arora's previous experience in General Practice and that he had not worked for approximately five years. The 2011 Panel noted that Dr Arora was asked to complete the test process but without a simulated surgery. In the Single Best Answer questions, Dr Arora scored 48.33%, which was below the minimum acceptable score of 66.89%. The qualitative findings of the assessment team were derived from the OSCE stations and second interview and indicated that the standard of Dr Arora's professional performance was unacceptable in the following areas:

- Assessment of the patient's condition.
- Providing or arranging treatment.
- Relationships with patients, listening to patients, respecting their views and providing comprehensible information.

19. The assessment team also found that Dr Arora's performance was a cause for concern in the following areas:

- Providing or arranging investigations.
- Other Good Clinical Care.

20. The assessment team had insufficient information to reach a judgement in relation to Dr Arora's record keeping, maintaining good medical practice, teaching and relationships with colleagues. The assessment team were of the opinion that Dr Arora's performance in the OSCE stations indicated that his clinical skills had deteriorated relative to the 2007 OSCE and had not improved relative to the 2004 performance assessment. In the key areas of assessment, treatment and relationships with patients, Dr Arora's observed performance was deemed to be unacceptable raising potential patient safety issues. The assessors were of the view that Dr Arora's consultation style appeared chaotic which impacted on all areas of his clinical performance. The assessment team concluded that Dr Arora expressed a willingness to retrain, but had not demonstrated that he was able to learn and had not improved sufficiently to return to medical practice. The assessment team was of the opinion that Dr Arora was unrealistic in his understanding of the time and degree of improvement which would be required to achieve the standard necessary for independent practice. The team did not believe that further remediation would be of any value and was of the unanimous view that Dr Arora was not fit to practise at all and should be erased from the register.

21. During the course of Dr Arora's oral evidence, he told the 2011 Panel that he last worked in a clinical capacity on 16 March 2006 and how he had experienced difficulties in obtaining a medical post, which he attributed to the stringent conditions imposed on his registration, which he said were unreasonable. Dr Arora had said he wished to return to unrestricted clinical practice, primarily in Ophthalmology but would also wish to work as a locum general practitioner. Dr Arora said that he did not consider his professional performance to be deficient given the efforts he had made to keep his medical knowledge and skills up to date. The 2011 Panel was satisfied that the performance assessment undertaken in October 2010 was fair and balanced, and that the assessment team had taken account of the fact that Dr Arora had been out of clinical practice since April 2006, and he had been assessed at the level of a recent graduate at the beginning of career training.

22. The 2011 Panel was concerned that, on the basis of the assessment report, Dr Arora's professional performance had deteriorated such that he was unable to perform basic key skills. The 2011 Panel noted that Dr Arora had attended a number of courses and had undertaken online learning, but it considered that he had not demonstrated that he was able to assimilate his learning into his clinical practice. The 2011 Panel was concerned by Dr Arora's lack of insight and that his focus on the unfairness of the process had distracted him

from the deficiencies identified in his professional performance. The 2011 Panel was particularly concerned that Dr Arora did not accept the findings of the assessment team or the decisions made by the previous Panels.

23. The 2011 Panel determined that Dr Arora had again breached his condition to produce a PDP. It accepted that in some circumstances submitting a PDP twelve days outside of the required time might not be significant, but given Dr Arora's previous history of breaches, he was aware of the requirement and importance of adhering to this condition. The 2011 Panel therefore determined this to be a serious breach. The 2011 Panel also considered the content of the PDP submitted in 2010 to be poor in comparison to the comprehensive PDP submitted in 2007/2008. It concluded that the PDP submitted was insufficient to meet the required criteria. The 2011 Panel determined that Dr Arora's fitness to practise was impaired by reason of his deficient professional performance and also by reason of his breaches of the conditions imposed.

24. The 2011 Panel was of the view that whilst Dr Arora had breached the conditions imposed on his registration, this was not the main issue in the case. It was concerned by Dr Arora's low skill level and that he had consistently failed to pass assessments and had been unable to put any learning into practice. The 2011 Panel was not satisfied that Dr Arora demonstrated he had the potential for remediation given his failure to remediate whilst under the imposition of conditions. The 2011 Panel was concerned that areas of Dr Arora's practice was found to be unsafe both by Dr C, Optometrist, and by the GMC performance assessment team. The 2011 Panel was particularly concerned at Dr Arora's lack of insight. It reminded itself of Dr Arora's oral evidence in which he told the 2011 Panel that his performance was not deficient and that he did not feel that he had any knowledge gaps compared with that of his peers. The 2011 Panel was not satisfied that Dr Arora had any insight into his deficiencies and weaknesses.

25. The 2011 Panel concluded that suspension was not appropriate, nor that Dr Arora had the potential to remediate his practice to an adequate standard, and it concluded that he presented a continuing risk to patient safety. The 2011 Panel determined that the proportionate and appropriate sanction was one of erasure. It therefore determined to erase Dr Arora's name from the Medical Register.

The Current Restoration Hearing

26. This Tribunal has convened to consider Dr Arora's first application for his name to be restored to the medical register in accordance with Section 41 of the Medical Act 1983 (as amended) and Rule 24 of the GMC (Fitness to Practise) Rules 2004 (as amended).

The Evidence

27. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to:

- The determinations of the Fitness to Practise Panels of 13-16 March 2006, 14-12 January 2008, 7-9 July 2008, 9-10 November 2009, and 31 May-2 June 2011;
- Transcript from the 31 May-2 June 2011 Fitness to Practise Panel;
- Restoration application, dated 24 November 2024;
- Email correspondence between Dr Arora and the GMC, various;
- Dated and undated documents, certificates and handwritten notes from Dr Arora, various;
- Continuous Professional Development ('CPD') certificates, handwritten notes and reading undertaken, various;
- GMC Performance Assessors' Report, May 2004
- Clinical Assessment, dated 11 April 2006;
- GMC Performance Assessment – test of competence, dated 5 November 2007;
- Performance Assessment Report, dated 29 October 2010;

Evidence on behalf of Dr Arora:

28. Dr Arora provided a bundle of documents in support of his application for restoration which included certificates of attendance on a number of courses. Further, such documentation was provided by Dr Arora during the course of the hearing.

29. Dr Arora also provided oral evidence during the hearing.

Summary of Dr Arora's oral evidence

30. Following questions by the Legally Qualified Chair, Dr Arora said that he finished his medical education at the age of 25 in 1971 and had seen patients for 40 years out of the 50 in which he had been a doctor in the UK. He said that he had been practising for about 35 years when he was told he had to be assessed. Dr Arora said that he did not accept the views of the performance assessors. When asked about the deficiency in respect of life support/resuscitation, Dr Arora told the Tribunal about a time he was working as a prison medical officer at Wandsworth prison between 2004 and 2006, when one of the prisoners hung himself and that he had resuscitated them. He said that in the OSCEs paid actors were used and told to act in a certain way, but when this event happened at the prison, the

prisoner was unconscious, his face was pale and lips were blue, that he requested the nurse to ring 999, that he put the prisoner's head on one side and started giving him mouth to mouth breathing and chest compressions. He questioned whether any of the assessors had ever done this practically, the answer was '*No'* Dr Arora said. He said these assessors pretended to be '*big teachers, dramatists'*, but had not done that which they were assessing. He said that he was in an actual emergency situation where the patient was dying and he saved his life in that moment, but in the assessment, he did not do it the way they wanted, and he was criticised for it. He said that the assessment was over 10 years ago, that he was a timid person then but now he could confront anyone and was more mature.

31. Dr Arora said that Dr C, whom he called an optician, came from Scotland and had been paid £1000 by the PCT to assess his capability as an Ophthalmologist. He queried Dr C's suitability to assess him. He stated that Dr C asked him to undertake several of the assessments he would have been expected to be undertake, record matters such as visual acuity, balancing of the lenses, or correct use of the ophthalmoscope. He said that the ophthalmoscope was the main instrument of an Ophthalmologist, like a stethoscope was for a GP. He said that was rudimentary. Dr Arora said that Dr C was loyal to the GMC as they paid him and he wrote his report. He said that the GMC should have assessed him as an ophthalmologist, but it was his mistake that he went into Genito-urinary medicine. Dr Arora said that around 2003 or so, the GMC / NHS were '*in very bad shape'* economically and they wanted to get doctors out because they could not afford them. Dr Arora said in respect of the bundles before this Tribunal, which included the previous Panel decisions and performance assessment reports, that this Tribunal should throw them away, that he thought they were burnt a long time ago but that they were being referred to again with the same old story. He said that the Tribunal should be looking at the conditions which the GMC imposed on him and that because of how stringent they were no one then wanted to give him a job.

32. Dr Arora said that he was deeply interested in going back into practice, not for money but because it was his passion. He said that one of the rooms in his house was full of medical books, and now because of the restrictions, he was finished in a minute and could no longer get any medical journals, attend a medical meeting or mix with my medical people. He said however that he was in America and a religious body said that they would like him to go to Ethiopia with them to do some ophthalmic eye examinations on patients. He said he jumped at the chance and subsequently went to Markos, the second largest city in Ethiopia, where he tested eyes for two weeks about five years ago. He said that when he returned to the UK he informed the GMC and they started groaning at him, asking him how could he see patients when he was restricted. He said that he just ignored them as they were very biased people who were against him.

33. Dr Arora then told the Tribunal about further courses and talks he had attended, which were not evidenced in the bundle. Dr Arora told the Tribunal about the high regard he was considered in India, but that the assessors in the UK had said that his attitude was very bad, that he was short tempered and that his communication was bad. Dr Arora told the Tribunal that he spoke the '*Queen's English, Parliamentary English*'. He said that when he was in his home village, in Piplee, India, he has treated patients for simple coughs, colds and fever and referred them to hospital if there was something that needed referral or to a chemist if they needed antibiotics. He said he would refer them by just telling them that they need to go to hospital. He said in India he would just provide guidance to those patients with their way of life, with sleeping, eating and matters of that nature. He said that when he went to Piplee it would be for around two to three weeks in which he would see patients, but that was not the main purpose of his visit, that he would be visiting family. He acknowledged that he was not able to do anything in the UK as he would be in breach of the GMC's restrictions.

34. In cross examination by Ms Dixon, Dr Arora was asked how he felt about the performance assessments and their fairness. He said that there were so many things the assessors said that his communication was poor, and he asked whether Ms Dixon could understand him. He said that he disagreed with the assessors about his patient assessment, investigations and treatment and said that he was a very devoted doctor. Dr Arora said that maybe one or two parts of the assessment were fair, but that most of it was not fair and was meant to demolish his personality, and his status in his surroundings with his friends among other things. Dr Arora confirmed that he still did not agree with the conclusions of the performance assessments. He said that if '*you*' were to take 10 random GPs at his level and test them for their assessments, communication, and all the other areas he was tested, he questioned whether they would pass, he said '*never*'. Dr Arora stated that his performance would be far better than others simply because he was the person who had been singled out, because he went from Ophthalmology to Genito-urinary medicine. He said that he would definitely be at least equal to if not better than both other Ophthalmologists and other GPs at his level. Dr Arora said that he meets these people every day, that their communication was not good, that they talk over other people and do not listen, whereas his listening was very good, that he tries to understand then he communicates. Dr Arora said that he thought his standard was good enough to be a senior Ophthalmologist.

35. Dr Arora confirmed that he was last employed in clinical practice as a doctor on 16 March 2006. He accepted that he had been out of practice 19 years, but that he has been working, seeing patients, reading medical journals, keeping in touch, attending international meetings as well as seeing patients face to face in Piplee, India. He said he would usually go to Piplee every six months and that he would see patients every time he went over. Dr Arora said that he did not have professional references from his work in Piplee as he never thought

he would have to prove anything to the GMC as they had nothing to do with him over there. He said he was 99% sure his restoration application would not be considered so did not keep any records.

36. Dr Arora was asked by Ms Dixon about whether he was able to obtain any type of employment in the medical field in the UK when his registration was subject to conditions between July 2007 to June 2011. He said that no one would give him employment under the conditions and when they saw the GMC's position that he had been erased, that they laughed at him. He said that he had been receiving help to try and find a job or attachment when he was subject to conditions in around 2007, and that he went to do shadowing at a nearby practice, with the help and clinical knowledge from his Dean, Professor B. Dr Arora said that the first day went ok; the second day he went with a pen and paper so that he could make some notes; and on the third day the principal GP thought that he may be making notes about confidential patient information and that they did not want him to return to the practice the following day. He also confirmed that he had not undertaken any paid or voluntary work in a healthcare setting in the UK after he was erased, from 2011 onwards. Dr Arora confirmed that he had not undertaken any university courses or medical diplomas since 2011.

37. Dr Arora said that he stopped going to talks or lectures in around 2019 as they no longer welcomed him, that he sometimes received information about talks, was unable to go but would love to go. He said that in order to keep his medical knowledge and skills up to date he had a room full of medical books, medical journals, geriatric medicine journals and other things. He said that he used to read those all the time and now he can find everything on the internet. He told the Tribunal about some of the articles he had read from his search history on his mobile phone.

38. Dr Arora was asked by Ms Dixon about specific areas of concern that were raised by the assessors in 2010 in which they found there were patient safety issues highlighted with respect to resuscitation and early diagnosis of cancer. She asked Dr Arora what steps he had he taken to improve his knowledge and skills in relation to resuscitation. Dr Arora again referred to the examples given earlier in respect of the prisoner at Wandsworth prison who hung himself, whom he resuscitated. He also said that he attended a course provided by ambulance staff but he could not recall when this was. In respect of cancer diagnosis, Dr Arora said that whether there was a possibility of lung cancer, prostate cancer or any other cancer, it was important to exclude these possibilities by taking good and detailed history, where he named various symptoms including the patient's age and checking for any lumps. Ms Dixon asked Dr Arora whether he had taken any specific courses or attended any lectures

targeted towards that specific area of knowledge. Dr Arora said that he would love to attend one if he were to come across one.

39. Ms Dixon asked Dr Arora what steps he has taken to improve his knowledge and skills in relation to patient communication, which as a cause for concern in the 2010 assessment. He said that self-evidently, he was speaking with Ms Dixon and that he was communicating with her in his normal way. He again said that he spoke *'Parliament English, the Queen's English'*, that he has learned correct grammar and listened to the radio and television to try and improve.

40. Ms Dixon then asked Dr Arora about information he provided in his restoration application form, indicating that from September 2016 to November 2024 he was conducting online services for medical consultations in India. She referred to an email in which Dr Arora subsequently clarified that he provided telephone medical consultations to his friends and family in Delhi and Punjab whenever they asked and that he did not receive any payment for this. Dr Arora clarified that he did not do very many of these and that in India it was very costly to see a doctors for a poor person, and that he just provided advice for very basic ailments.

41. Ms Dixon asked Dr Arora, were he to be restored to the register, what kind of practice did he wish to return to. Dr Arora said that what he would do first would be to have a gathering party to let his friends know that he was back on the register and use that opportunity to seek out opportunities for shadowing in a GP practice, see how the computer systems works and how they deal with patents to develop his confidence and maybe they would give him a job. Ms Dixon asked Dr Arora whether he had taken any steps to keep up to date with advancements in technology, such as that used in record keeping, whilst he has been erased. Dr Arora said that he would once he is a part of a practice and that he would spend time with the receptionist to learn how to use the computer.

42. During Tribunal questions, Dr Arora was asked, if he were restored to the register and friends or family came to him for a consultation, would he still consult with them. Dr Arora said *'Yes, why not?'* He was asked whether he was aware of the GMC's guidance about treating friends and family and how that has changed over the years. He said the *'GMC may consult friends and family and GMC may ask them what I have talked to them or something.'* Dr Arora was asked whether he was aware of Good Medical Practice and whether he had read it. He confirmed that he had and acknowledged that he should not be consulting with friends and family in this country, but if somebody met him outside the UK, he was free to do so. He said that were they to consult with him whilst he was in this country if he was restored to the register, he would tell them they should consult another doctor.

43. Dr Arora said that he did not have a PDP prepared, that it was difficult for him to do one whilst he has been erased, but that if he was given the slightest indication that he was to be restored, he would start preparing one. In respect of the courses and talks he has attended, Dr Arora confirmed that the varied nature of the ones attended were due to what he had seen advertised as opposed to him considering that he needed more knowledge in that particular area. He confirmed that Professor B was his last mentor, but that he retired without letting Dr Arora know. He had not arrange for another mentor since. It was put to Dr Arora that the Tribunal needed to be satisfied that he was safe to practise unrestricted and could he explain why he considered that he was now safe to return to unrestricted practice. Dr Arora said that he would self-assess if he were restored, that he would not go forward blindly, that he would ask friends for support, for them to let him work in their practice shadowing them and to see how they worked, see which computer to use, attend reception and see how patients are booked in and follow the routine. He said that only then, when he was familiar, would he start to be independent by himself.

Submissions on behalf of the GMC

44. Ms Dixon submitted that it was for Dr Arora to satisfy the Tribunal that he was fit to return to unrestricted practice and that the GMC did not have to prove anything. She referred the Tribunal to the *'MPTS guidance for medical practitioners tribunals on restoration following disciplinary erasure'* ('the Guidance'), which provided a detailed framework to assist the Tribunal in applying the statutory test as set out at Section 41 of the Medical Act, and which could also be found in the case of *Chandra*. Ms Dixon submitted that the test to be applied when considering if a doctor should be restored was that having considered the circumstances which led to erasure, and the extent of remediation and insight, whether the doctor was now fit to practise having regard to each of the three elements of the overarching objective. Ms Dixon submitted that in this case, the Tribunal may feel the answer was no.

45. Ms Dixon submitted that whilst it was commendable that Dr Arora has maintained an interest in medicine and wished to return to practise, he has simply not demonstrated that he was now fit to practise after 19 years out of employed clinical practice, and 14 years off the register. She said that whilst it appeared that Dr Arora has undertaken some limited voluntary work in India and Ethiopia, the Tribunal may feel this was simply not sufficient to demonstrate that the serious and wide-ranging deficiencies in his professional performance have been remediated.

46. When considering the circumstances that led to the disciplinary erasure, she highlighted that Dr Arora failed three GMC performance assessments in 2004, 2007 and

2010. She said this was despite having the opportunity in intervening years between the assessments to undertake further study and training to remediate his professional deficiencies. Ms Dixon said that Dr Arora also failed the assessment conducted by Dr C in April of 2006, with Dr C concluding that Dr Arora was unsafe and not fit to practise, and that Dr Arora also failed two London Deanery return to practise assessments. Ms Dixon acknowledged that Dr Arora did demonstrate some improvement in 2007, but that improvement was not sufficient for him to pass the knowledge test on that occasion. She said that Dr Arora's performance then deteriorated between 2007 and the final assessment in 2010, demonstrating that, not only were his efforts of remediation at that stage insufficient, but also that he had not kept his knowledge and skills up to date. Ms Dixon said that whilst Dr Arora had provided a number of certificates indicating online learning and attendance on courses, there was no apparent pattern or plan to this learning. She said that Dr Arora's knowledge test results from the 2010 assessment remained below the acceptable minimum standard despite the number of courses and time available for study. Ms Dixon said that how matters were left in 2011 was that Dr Arora was not fit to practise. She said he has been found unsafe by Dr C in 2006, and that he was not fit to practise as a general practitioner, even at the level of a recent graduate at the beginning of career training due to deficient professional performance in a number of areas. She said he posed a risk to patient safety.

47. When considering the question of whether Dr Arora has demonstrated insight into the matters that led to his erasure, Ms Dixon reminded the Tribunal that the 2010 Panel was not satisfied that Dr Arora had any insight into his deficiencies and weaknesses. She said that this Tribunal may feel that the position remains unchanged. She said that Dr Arora's focus in his evidence was on the deficiencies with the performance assessment process itself, and with the opinions given by the lead assessor, rather than reflecting on his own clinical performance and areas for improvement. Ms Dixon submitted that it appeared that Dr Arora still did not accept the findings of the performance assessments and was still of the view that his professional performance was either better than, or at the level of, other GPs and ophthalmologists of his level of experience. She said that the Tribunal may feel that Dr Arora simply still did not understand the full extent of the deficiencies in his professional performance, or the comprehensive remediation that would be required to remedy them, particularly after so long out of clinical practice.

48. Ms Dixon submitted that, as a result of Dr Arora's lack of insight, the Tribunal may be of the view that there would be a continuing risk to patient safety if he were permitted to return to practise. She said the risk of repetition was particularly high due to the lack of any structured, measurable and comprehensive remediation on the part of Dr Arora. Ms Dixon said that he has attended a number of courses and lectures, the last course certificate however was from 2019 and the last notes were from 2020. She said that Dr Arora had not

taken a structured approach in selecting courses and lectures that address the specific deficiencies that arose in the previous performance assessments. She said the Tribunal may think this was because Dr Arora did not accept the findings of those assessments. Ms Dixon invited the Tribunal to consider that Dr Arora has undertaken no comprehensive remedial study or training on resuscitation, one of the key deficiencies identified in the performance assessment, save for some life support training with ambulance staff. She said that Dr Arora did not recall the precise date he undertook that training, though it may have been in the last three years. She also said that Dr Arora had not undertaken any training or study on the recognition and early diagnosis of cancer, another key deficiency highlighted in the performance assessment, or on communicating effectively with patients. She submitted that the steps Dr Arora has taken to remediate simply did not come close to being sufficient to remedy the serious and wide-ranging failings that arose in his previous performance assessments, and in the determinations of the previous Panels. She submitted that Dr Arora has done nothing in the period from his erasure which he was not already doing in the lead up to the final failed performance assessment. She submitted that there had not been any comprehensive shift in his approach to try and target the specific deficiencies and that the Tribunal may feel that it is more likely that the deficiencies in his professional performance will have been exacerbated by the long period out of clinical practice. She said that, as a result, the risk of repetition remained high.

49. Ms Dixon submitted that the Tribunal may feel that Dr Arora has not taken sufficient steps to keep his knowledge and skills up to date. She said that in his oral evidence, Dr Arora described having medical books at home, that he used to receive medical journals, and that he conducted his own research using Google. She said he had not however undertaken any shadowing or observing, other than two days of shadowing several years prior to his erasure, nor had he worked in any kind of healthcare related field during his erasure to keep up to date. Ms Dixon said Dr Arora has not undertaken any academic qualification in the medical field or any paid or voluntary work in the healthcare sector, nor has he sought to keep himself up to date with advancements in medical technology. She said that the Tribunal may feel, as a result, that it was likely Dr Arora's knowledge and skills have deteriorated in the time since his erasure and that the risk to patient safety was in fact higher than it was in 2011 when he was erased.

50. When considering whether Dr Arora was fit to practise having regard to the three limbs of the overarching objective, Ms Dixon submitted that Dr Arora has not demonstrated to this Tribunal that he is fit to practise having regard to those three limbs. In respect of promoting and maintaining the health and safety and well-being of the public, she said that the risk to patient safety would be high if Dr Arora were permitted to return to practise unrestricted as he has not remediated the wide-ranging deficiencies in his professional

practice. She said that public confidence in the profession would no doubt be diminished if Dr Arora were permitted to return to practise. She said the Tribunal may feel that an ordinary, well-informed member of the public would be very concerned to hear that a doctor with Dr Arora's history of failed performance assessments simply returned to practise, particularly in circumstances where he has done very little remedial work and has not undertaken robust and targeted retraining. Ms Dixon submitted that granting Dr Arora's application for restoration would not promote and maintain proper professional standards of conduct. She said that Dr Arora has repeatedly demonstrated that the standards of his professional knowledge and performance were deficient in a number of areas. Ms Dixon submitted that, taking all of the circumstances into account, the Tribunal may feel that restoring Dr Arora to the register would simply not meet the overarching objective, and therefore the application ought to be refused.

Submissions made by Dr Arora

51. Dr Arora said that 99% of what Ms Dixon submitted was totally wrong. He submitted that when he had so many restrictive conditions imposed upon his registration that he was not able to mix with people, and that he was not able to do what was expected of him. He said with an opportunity, he would do what was expected of him but that he had done the maximum of what he could do. Dr Arora accepted that he has been away from practice for a long time but that he had been studying. He submitted that there were no specific areas of the medicine he was targeting because he was aiming to go into General Practice. He submitted that he has worked in Ethiopia and India, that he had undertaken more training there, stayed in touch with the patients, and he did not think that they would consider him dangerous. Dr Arora said that his application was genuine and that he had insight. Dr Arora repeated that he considered that he was better than, or at least equal to the other GPs he has met here on a day-to-day level. He invited Ms Dixon to take ten GPs at random and test them regarding communication, note-taking, investigations and other areas which he had failed on in his performance assessments. He submitted that he was far better that those GPs who were just routinely doing the same thing, that they went home and never studied. He said that he had a room full of so many books and that he has kept his level of education up to date and as much as possible, despite the fact that the GMC had been very harsh on him. Dr Arora questioned the point of the harsh conditions placed on his registration. He submitted that the GMC did not have insight into the public dying while waiting to see doctors, that even he would not be able to get an appointment soon as the phone was not answered when trying to contact a GP practice. He said good doctors are made to sit at home when they are not dangerous, spoiling the reputation (of the profession) whilst patients were crying in pain and suffering. He said that this was not a question of the GMC versus Dr Arora, rather that it was a question of the benefit of general public and that he was a qualified

doctor. He said that being restored to the register was not about money, rather that he still had a '*zest',* wanted to help people and continue with his profession.

52. Dr Arora submitted that the only reason this silly problem arose was because he moved from Ophthalmology to the nice decent subject of Genito-urinary medicine, and that without being consulted or having been provided the slightest piece of information, he was referred to the GMC. He submitted that this was his first restoration application, that he felt strong and, once he is given the opportunity, he will be fine working. Dr Arora submitted that he has already worked for more than 35 years without any blame, without the GMC raising a finger, but they stopped his career '*just for a little thing*'. Dr Arora said that the GMC put too much pressure on doctors and on the medical profession.

53. In respect of remedial action regarding education, Dr Arora submitted that Ms Dixon said he had not completed much education. He said that he has not been allowed to see any patients, that on the one hand he is told to undergo an assessment and improve his education, then on the other hand he is told that he has broken his conditions. Dr Arora suggested that the GMC should sit down and talk with a doctor and ask them of their intention, to find out the character of the doctor, rather than sitting there with the hanging rope in their in their hands just to put on any doctor. He invited the Tribunal to disregard what the GMC has said about him having no insight, he said that the GMC had no insight and did not know how to manage the medical practice. He said that he was still allowed to practise under the Indian Medical Council. Dr Arora detailed the circumstances of a successful eye operation he had been a part of at a hospital in Kidderminster where a patient's vision was restored and about the devotion he used to have. He said that he would return to India to practise had he not made roots in England, that he was now stuck here and that he could not go anywhere else. Dr Arora submitted that all the GMC understood was how to remove doctors from the register. He said that in respect of the general public and the reputation of the GMC, he strongly requested the reconsideration of his application for restoration.

The Tribunal's Approach

54. The Tribunal reminded itself that its power to restore a practitioner to the medical register is a discretionary power to be exercised in the context of the Tribunal's primary responsibility to act in accordance with the statutory overarching objective, to protect the public.

55. Whilst the Tribunal has borne in mind the submissions made by the parties, the decision as to whether to restore Dr Arora's name to the medical register is a matter for this Tribunal exercising its own judgment.

56. Throughout its consideration of Dr Arora's application for restoration, the Tribunal was guided by the approach laid out in the Guidance.

57. The Tribunal reminded itself that the onus is on Dr Arora to satisfy it that he is fit to return to unrestricted practice and that the Tribunal should not seek to go behind the original Tribunal finding on facts and impairment. The Tribunal was mindful that if granted, restoration returns a doctor to full unrestricted practice and that it did not have the power to accept undertakings or impose conditions upon a doctor's practice when being restored to the register.

58. The test to be applied by Tribunals when considering if a doctor should be restored is that set out in *GMC v Chandra [2018] EWCA Civ 1898*, namely: "*having considered the circumstances which led to erasure and the extent of remediation and insight, is the doctor now fit to practise having regard to each of the three elements of the overarching objective*".

59. The Tribunal reminded itself that, in making its decision, it should consider the following factors:

- the circumstances that led to disciplinary erasure;
- whether the doctor has demonstrated insight into the matters that led to erasure, taken responsibility for their actions, and actively addressed the findings about their behaviour and skills including consideration of:

    - insight and remorse;
    - remediation and risk of repetition;
    - whether findings about the doctor's behaviour have been remedied;
    - likelihood of repetition of the previous findings about the doctor's behaviour;

- The MPT should also consider any activities the doctor has undertaken since erasure and whether these are relevant to their current fitness to practise. Examples of things which may have a bearing on the tribunal's decision are whether:

    - the doctor has obtained employment in a field related to medicine and used it to keep up to date with developments in their specialty

- the doctor has completed a professional or academic qualification such as a PhD, diploma or MSc in a relevant subject

- steps the doctor has taken to keep their skills and knowledge up to date; and
- the lapse of time since erasure.

60. After considering these factors, the Tribunal reminded itself it should step back and balance its findings against whether restoration meets the overarching objective. In making its decision, the Tribunal took account of all the evidence before it, both oral and documentary, along with the submissions made.

The Tribunal's Decision

The circumstances that led to disciplinary erasure

61. The Tribunal reminded itself of the detailed background, as set out above, in respect of the circumstances of Dr Arora's case and those which led to his erasure from the medical register in June 2011. It reminded itself of the determination of the previous Panels. It noted the observations and conclusions of the 2011 Panel in determining to erase Dr Arora's name from the medical register. This Tribunal was of the view that much of the 2011 Panel's reasoning and comments were applicable today, that it was concerned by Dr Arora's low skill level, that he had consistently failed to pass assessments and had been unable to put any learning into practice. It was also not satisfied that Dr Arora demonstrated any significant remediation since his erasure and that he continued to lack insight, having maintained that his performance was not deficient and that he did not feel that he had any knowledge gaps compared with that of his peers. Rather, it was clear that Dr Arora remained of the view that the deficiencies were with the assessment process and those who assessed him. In the circumstances, the Tribunal considered that Dr Arora presented a continuing risk to patient safety. The Tribunal considered that Dr Arora had not demonstrated that anything has materially changed since his erasure in 2011.

Whether the doctor has demonstrated insight into the matters that led to erasure, taken responsibility for their actions, and actively addressed the findings about their behaviour or skills

62. The Tribunal noted that when Dr Arora was erased in 2011, the Panel was not satisfied that he had any insight into his deficiencies and weaknesses. The Tribunal was of the view that it did not appear that Dr Arora had moved forward from that position or developed any insight during the intervening years. Dr Arora has, if anything, grown more entrenched in

his views in respect of the assessments being unfair and the merits or lack thereof of the assessor's qualifications to assess him. There was little acknowledgement from Dr Arora of the findings of the performance assessments, or the subsequent Panel decisions in respect of his own failings, what he has done to address those failings, whether he has reflected on them, or how he would do things differently in the future. He provided no meaningful understanding of the impact of his time out of practice (for example, how the passage of time and developments in medicine would have reduced his skills and knowledge further) nor of what steps he would need to take be safe to return to unrestricted practice. He said that were he to be restored to the register, he would first throw a '*gathering party*' and invite those who may be able to assist him in supervision, but there was no evidence that he had made any demonstrable proactive steps towards non-clinical attachments, mentorship or supervision since his erasure. He said that were he to be restored, he would seek assistance from a receptionist to help him with the computer systems he would have to use. The Tribunal had before it no evidence that Dr Arora had undertaken any form of basic computer courses to address deficiencies in his technical abilities, nor had he undertaken any courses in communicating with patients.

63. Dr Arora also appeared to have a lack of insight into how his deficient professional performance could impact patient safety, public confidence in the profession and proper professional standards for members of the profession. Rather, Dr Arora blamed the GMC for this situation and claimed that it lacked insight into these matters and said that he was currently at a level of standard higher than other GPs.

64. The Tribunal noted that in one of his performance assessments, Dr Arora went over the time allotted for the test and he wanted more time. The assessor told him that he had already had sufficient time and required him to stop. This still appeared to agitate Dr Arora.

65. Dr Arora has not accepted or acknowledged the reasons behind why he was erased. Rather, he said that the NHS got rid of him because they could not afford to keep him on and that it was for financial reasons, and that he had an unblemished career and because of one small thing they got rid of him, he did not accept any personal responsibility for his deficient professional performance.

66. Dr Arora said that he was as good as if not better than most GPs and that they did not study, whereas he did. The Tribunal noted that all doctors have an annual appraisal in which they have to demonstrate Continuous Professional Development, and that they have to revalidate every five years. Dr Arora was not however able to demonstrate any significant learning or targeted Continuous Professional Development in recent years. The Tribunal agreed with the view of previous panels that Dr Arora underestimated the gravity of the

performance concerns and what he would need to do to address them. He was also not able to demonstrate any detailed insights or reflections on learning he has undertaken in respect of the courses, talks or reading he has undertaken or how they might impact future practice.

67. The Tribunal was satisfied that Dr Arora's level of insight did not appear to have developed since the 2011 Panel erased him from the medical register.

Remediation and risk of repetition

68. The Tribunal noted that the Guidance set out that:

> *"B14 For remediation to be judged successful it must be focused on activities that reduce the level of risk posed to patients, members of the public and to public confidence in the profession from allowing the doctor to return to practice. Efforts to remediate should be driven by the doctor with support from others as appropriate."*

69. When considering whether Dr Arora had fully remediated his deficient performance, the Tribunal again reminded itself that Dr Arora attended some courses and talks. Dr Arora accepted that the courses and talks he attended were not targeted or on topics of his choosing, rather they were ones held within his geographical area and ones in which he was allowed to attend. He said that in order to work in general practice, all areas of knowledge were useful as you would not know the needs of that patient attending a consultation. He also accepted that were he to be restored to the register, he would undertake further training.

70. The Tribunal considered however, that the courses and talks that Dr Arora had attended were not structed or targeted to his deficiencies, for example in Basic Life Support, early diagnosis of cancer or patient communication skills. He was also not able to say when he had attended a number of the courses he had attended, how many years ago, or give details of the learning and reflections he had taken away from those courses. He was unable to explain the impact of his learning and reflections on how he would use this learning in day-to-day practice. The Tribunal was of the view that Dr Arora had a scatter-gun approach in the courses and talks he had attended.

71. Dr Arora told the Tribunal about having attended an emergency medicine course which was provided by the ambulance service, yet in the subsequent performance assessment, Dr Arora scored zero in that area of knowledge. It appeared that he had learned nothing from attending that course, or was unable to apply what he learned to that scenario in the assessment. He also appeared to remain of the view that because he had resuscitated

a patient many years ago, his knowledge and skills in this area were sufficient, despite changes in practice since then.

72. The Tribunal noted that Dr Arora had not produced a recent PDP to target the areas of deficiency previously identified by the performance assessments and previous Panels. The Tribunal further noted that whilst previous PDPs had been prepared by Dr Arora, which were not before it in this hearing, these had been considered to be inadequate for what they ought to contain.

73. Dr Arora told the Tribunal about work he had undertaken in Piplee, India in which he had been working as a doctor advising family and friends. The Tribunal accepted that he had carried out this ad hoc voluntary work. However, Dr Arora was unable to demonstrate and evidence any record keeping, or any learning from that work which may have addressed his deficiencies.

74. Dr Arora told the Tribunal that if there were communications courses available, he would jump at the chance to take them. The Tribunal considered it was unlikely that were was not a course in communication skills nor a book on the same which he could have attended or used in the last 14 years since he was erased.

75. In respect of his computer skills, the Tribunal was of the same view, that Dr Arora could easily have undertaken a basic computer skills course within the last 14 years.

76. In trying to demonstrate reading he has undertaken, Dr Arora scrolled through his mobile phone google search history, trying to identify articles he had read. He had not provided an organised reading list and was trying to find the evidence in the moment when giving his oral evidence. The Tribunal noted that whist there were open access journals available online, it had no evidence who authored the articles Dr Arora read, at what audience they were directed, medical professionals or general members of the public, or whether they were recent, up to date and/or peer reviewed.

77. The Tribunal noted that the deficiencies for which Dr Arora was erased were remediable as they were deficient performance concerns, and that over a period of 5 years leading up to Dr Arora's erasure, he was unable to remediate those performance deficiencies or improve, and in fact, his knowledge and skills had deteriorated. The 2011 Panel determined that Dr Arora's performance was so poor that it was no longer remediable. Dr Arora has not demonstrated to this Tribunal that he has remediated his performance from the level of a basic GP trainee level, from when he was erased to the time of these proceedings.

78. When considering the likelihood of repetition and the extent of Dr Arora's insight, the Tribunal considered whether the steps that Dr Arora has taken to remediate were sufficient to achieve public protection. The Tribunal was of the view that Dr Arora has demonstrated a persistent lack of insight and that there was a high likelihood of repetition of his deficient performance should Dr Arora return to fully unrestricted practice. It was not of the view that that the limited courses and talks attended and '*scatter gun'* approach to reading, was sufficient to achieve public protection. The Tribunal was of the view that there was a high risk of repetition of deficient performance given the lack of targeted remediation and persistent lack of insight.

What the doctor has done since their name was erased from the register

79. Dr Arora has undertaken voluntary work in India and Ethiopia since his erasure, but in respect of his work in both countries the Tribunal had before it no evidence of the work he undertook, when he undertook it, evidence of medical records, learning or reflections undertaken from those experiences, or whether he targeted or addressed any of the concerns raised in the performance assessments. Dr Arora said that he helped his family and friends in Piplee, India, but this work was infrequent, would be dealing with minor ailments and there was no positive evidence to demonstrate remediation or targeted learning.

80. Dr Arora provided no evidence that he has tried to proactively undertake any other steps to seek out and obtain observational roles, voluntary roles or a mentor to try and help him work towards being restored to the register. Whilst he had a mentor in the past, this lapsed when his mentor retired and he has not sought to arrange for another mentor, therefore he has not had the support of a mentor or supervisor for many years now. He also provided no evidence that he has undertaken professional or academic qualification or training, nor has he undertaken any laboratory work or written any medical articles, though he has undertaken reading at home.

The steps the doctor has taken to keep their medical knowledge and skills up to date

81. The Tribunal reminded itself that the onus was on Dr Arora to demonstrate he has kept his medical knowledge and skills up to date and was safe to resume unrestricted practice. When Dr Arora was erased, the 2011 Panel determined that he was below that standard expected even at a training level, so he would have to improve his deficient professional performance up that that standard as a minimum. The only evidence it had before it was that Dr Arora has attended some courses, talks and done some reading at home, and had not targeted any to address his deficiencies. Many of the courses and talks

attended were over five years ago, and he was not able to speak in any depth about the most recent courses or talks attended, or his learning from them.

82. The Tribunal noted that the Guidance sets out that *"Less weight should usually be given to online courses as these do not generally provide a proper opportunity for a doctor to witness doctor/patient interaction first hand and this can limit their value."* Some of Dr Arora's reading was from books he has in his own home, and other reading was from online sources. Dr Arora did not tell the Tribunal as to how much of his reading was from online sources. In any event, he was not able to speak in any significant depth of his learning and reflection from his reading and how he would implement that learning in day-to-day practice.

83. The Tribunal considered that whilst it had the power to direct a further performance review, there was little necessity for this given that Dr Arora had already been assessed in total six times, which he has not passed, he has undertaken little remedial work, lacked insight into his performance, did not accept the findings of the previous assessments, or that of the previous Panels, and that the circumstances of Dr Arora's deficient performance were no further forward then they were 14 years ago.

84. The Tribunal therefore was not satisfied that Dr Arora had the requisite level of knowledge or skills to return to unrestricted practice.

<u>The lapse of time since erasure</u>

85. The Tribunal took account of paragraph B34 of the guidance:

> *"The longer the doctor has been away from clinical practice, the greater the likelihood that their knowledge and skills will have deteriorated to a degree that may place patients at risk. Tribunals should pay close regard to how the doctor has maintained their knowledge during a lengthy period away from the register."*

86. The Tribunal was of the view that for a doctor to have been out of unrestricted medical practice for 19 years, and having been erased 14 years ago, was a particularly long period of time. Even more so when there was no evidence that Dr Arora has not completed any significant progress in addressing the concerns about his deficient performance.

Will restoration meet the overarching objective?

87. The Tribunal next had regard to the statutory overarching objective. In so doing, it performed a balancing exercise, weighing its findings above with its obligations under the individual limbs of the overarching objective which are:

a. To protect, promote and maintain the health, safety and well-being of the public;
b. To promote and maintain public confidence in the profession; and
c. To promote and maintain proper professional standards and conduct for members of that profession.

88. The Tribunal was of the view that allowing Dr Arora to return to unrestricted practice when he lacks insight into his deficient performance, has not remediated those concerns, that there was a high risk of repetition of those concerns, would create an unacceptable a risk of harm to patients. As such, it concluded that restoration of Dr Arora to the medical register would undermine public safety.

89. When considering public confidence in the profession, the Tribunal was satisfied that an ordinary, well-informed member of the public would be very concerned to hear that a doctor with Dr Arora's history of failed performance assessments was allowed to return to unrestricted practice. It was of the view that such a decision would not be consistent with its decision in respect of the first limb and would be undermined public confidence in the profession. It follows that public confidence would not be upheld if Dr Arora were permitted to be restored to the medical register at this point in time.

90. When considering the third limb of the overarching objective, the Tribunal considered that maintaining proper professional standards for members of the medical profession was linked to, and was undermined by, Dr Arora's continued deficient professional performance. Dr Arora failed six performance assessments and demonstrated no evidence of improvement by the time of the final one resulting in the 2011 Tribunal's decision to erase his from the register. Dr Arora is no further on in his development, and restoring his name to the medical register to allow him to return to unrestricted practice would undermine proper professional standards for members of the medical profession.

Conclusion

91. Having carefully considered all the evidence and specific circumstances of this case, the Tribunal was not satisfied that Dr Arora is fit to return to unrestricted practice.

Accordingly, the Tribunal refused Dr Arora's application to be restored to the Medical Register. He cannot make a further restoration application for 12 months.