

CHAPTER TWENTY THREE

How the General Medical Council Deals with Cases of Drug Abuse

Introduction

- 23.1 In Chapter 16, I described how the General Medical Council (GMC) dealt with the report it received of Shipman's convictions in February 1976. Those convictions were for a series of offences of unlawful possession of pethidine, dishonestly obtaining pethidine and forgery of prescriptions for pethidine. He had been dishonestly obtaining large quantities of pethidine in Todmorden for a period of about 18 months before he was eventually detected. He claimed that he had obtained the drug to satisfy his own habit and, having considered all the evidence, I am satisfied that that was indeed the case. When the convictions were reported to the GMC, the Penal Cases Committee (PeCC) decided to close the case with a warning to Shipman not to repeat his previous misconduct.
- 23.2 Following Shipman's convictions for murder in January 2000, there was considerable public disquiet when it became known that he had previously been convicted of controlled drugs offences. A number of the relatives of his victims expressed the view that a doctor who has misused controlled drugs, as Shipman had, should never again be allowed to practise medicine, at least not without appropriate monitoring and supervision.
- 23.3 In the light of the public disquiet expressed about the way in which the GMC permitted Shipman to continue in practice following his conviction, I wanted to examine how the GMC had handled cases similar to his over the past 30 years. My discussion will be confined to cases where a doctor has misused controlled drugs by consuming them him/herself. I shall not deal with the situation where the doctor has prescribed irresponsibly for patients or non-patients or has otherwise been involved in the supply of drugs to others. Quite different considerations apply to that sort of case.
- 23.4 In Chapter 16, I concluded that the PeCC's approach to Shipman's case was typical of its approach to similar cases at that time. The GMC took what amounted to a rehabilitative approach to such cases although the health procedures were not then in place. I described the health procedures, which came into effect in 1980, in Chapter 22. The evidence received by the Inquiry suggests that, since 1980, virtually all cases involving the misuse of controlled drugs have been dealt with through those procedures. Dr Sheila Mann, a health screener from 1998 until 2004, told the Inquiry in December 2003 that, if Shipman's case had come to the GMC then, he would almost certainly have been referred into the voluntary health procedures. However, the Inquiry became aware of evidence that suggests that the GMC may have recently begun to take a different approach to some cases of this type. The Inquiry has come across one case involving a doctor convicted of drugs offences who was dealt with through the conduct procedures rather than being referred into the voluntary health procedures, despite there being some evidence that he had a related psychiatric problem. The result was that the Professional Conduct Committee (PCC) erased the doctor's name from the register. There may be other such cases of which I am not aware. Thus it cannot be assumed that, if Shipman were to have been convicted in late 2002 or 2003, he would necessarily have been dealt with in the

voluntary health procedures. Moreover, as I shall explain in Chapter 25, under the new fitness to practise (FTP) procedures, convictions for offences connected with drug abuse are likely to be referred to a FTP panel. The panel will have the power to impose conditions upon the doctor's practice or to refer the doctor into the voluntary health procedures but it will have other sanctions available to it.

- 23.5 In this Chapter, I propose to examine the recent case in which the drug abusing doctor was erased from the register and the circumstances in which it came to be dealt with as it was. I shall consider another case of a similar kind which, at almost the same time, was referred into the voluntary health procedures. I shall then examine the rationale behind the GMC's approach to cases of this kind and will consider what, in my view, the approach should be under the new procedures. These questions are of particular importance because the Inquiry's Terms of Reference require me to recommend any changes that I consider necessary for the protection of patients in the future.
- 23.6 Drug abuse is a significant problem in the medical profession, although the precise extent of it is not known. Moreover, the problem is unlikely to decrease. Professor Sir Michael Rawlins, former Chairman, Advisory Council on the Misuse of Drugs, and current Chairman, National Institute for Clinical Excellence, spoke at one of the Inquiry's seminars of the significant problem of misuse of controlled drugs by students, including medical students. Surveys suggest that cannabis is used by between 10% and 20% of pre-registration house officers and 'Ecstasy' by between 5% and 10%. This is a 'grave worry for the future' because, according to Sir Michael, as these doctors progress in their careers they will have much greater and easier access to 'more nasty drugs' than the rest of the population has.

Two Cases Considered by the Preliminary Proceedings Committee in November 2002

A Change of Approach following the Case of Crabbie

- 23.7 The meeting of the Preliminary Proceedings Committee (PPC) which took place in November 2002 was the second meeting after the Privy Council had delivered its judgement in the case of Crabbie v General Medical Council¹. Mr Finlay Scott, Chief Executive of the GMC, told the Inquiry that this case should, in principle, have had an important effect on decisions made by the PPC.
- 23.8 In Crabbie, the doctor had been convicted of causing death by dangerous driving. It was a very bad case. She had driven a motor car while under the influence of drink and had collided head-on with another vehicle, killing one person and seriously injuring two others. She was sentenced to five years' imprisonment. Although there was evidence that her dependence on alcohol amounted to an illness, Dr Crabbie's case was referred to the PCC and her name was erased because of the nature and gravity of the offence. It must inevitably have brought the profession into disrepute. Her appeal to the Privy Council was founded on the argument that the PCC should have referred her case to the Health Committee (HC) for the imposition of conditions on her registration. I interpose to point out

¹ [2002] 1 WLR 3104.

that, had that been done, her name could not have been erased from the register. The Judicial Committee of the Privy Council held that the PCC's approach had been correct and its decision reasonable. The judgement was delivered on 23rd September 2002.

- 23.9 The Privy Council added a rider to its judgement, to the effect that GMC decision-makers should not refer a case to the HC if there were any possibility that the doctor's name might be erased from the register. At first sight, that seems no more than common sense, because, once a case had been referred into the health procedures, erasure would never be available and the GMC would have deprived itself of an important means of protecting the public. The judgement in Crabbie did not seek to affect the approach that the GMC had historically taken to any particular type of case. It did not seek to suggest that the GMC ought to be erasing more doctors from the register. It said only that, if erasure were a possibility, the case should go through the conduct procedures (in practice to the PCC) until erasure had been considered. If erasure were ruled out, the case could then, if appropriate, be referred to the HC. Mr Scott said that Crabbie should have important implications for the way in which such cases as Shipman's were dealt with. He said that such convictions were so serious that they must give rise to a possibility of erasure and that all cases in which erasure was a possible sanction should, as a matter of principle, be referred to the PCC (under the old procedures) or to a FTP panel (under the new procedures). It should no longer be appropriate in any case in which erasure was a possibility to refer the doctor into the voluntary health procedures at a preliminary stage.
- 23.10 As Mr Scott conceded, this would have entailed a considerable difference of approach to cases involving drug abuse from that which had been taken previously. Mr Scott did not say that the new principle had already been put into effect under the existing procedures – only that the logic of the judgement in Crabbie would suggest that it should. Although Mr Scott confined his evidence on this issue to conviction cases, there could be no logical distinction between conviction cases and cases where there was an allegation of drug abuse involving dishonesty but where there had been no conviction.
- 23.11 At the November 2002 meeting of the PPC, two cases involving doctors convicted of offences of dishonesty in the context of drug abuse came up for consideration.

The Case of Rogers

- 23.12 In November 2001, Dr John Rogers, a general practitioner (GP), pleaded guilty to a series of offences of obtaining a Class A controlled drug by deception and of unlawful possession of Class A controlled drugs. He had obtained them for the purpose of self-administration. Those were the same offences of which Shipman had been convicted; other doctors whose cases I have examined in Chapter 22 had also committed similar offences. The Magistrates' Court committed Dr Rogers to the Crown Court for sentence, a course which suggested that the Magistrates regarded their sentencing powers (a maximum of 12 months' imprisonment) as inadequate. The Judge remarked that the offences amounted to a serious breach of the trust that the community placed in a GP. Dr Rogers had damaged his own reputation and that of the profession. He observed that no one else had been harmed by the doctor's actions. The same remarks might well have been made in Shipman's case in 1976 or, indeed, in any one of a large number of similar

cases I have looked at. After noting that the doctor had been suffering from depression, the Judge imposed a suspended sentence of imprisonment.

- 23.13 At the GMC, Dr Rogers' case was referred to the PPC which first considered it at a meeting in May 2002. One medical report, which had been prepared for the criminal proceedings, was already available. It expressed the view that Dr Rogers' offending had been secondary to his longstanding depressive illness. The PPC adjourned the case for further medical reports, a typical decision for the PPC in this type of case. The case was next considered in November 2002, when two further medical reports were ready. Although these reports confirmed that the doctor had been suffering from depression at the time of the offences, at least one of the medical examiners felt unable to reach a clear diagnosis of the extent of Dr Rogers' medical problem. The discussion of this case included consideration of the effect of the Privy Council's observations in Crabbie on the instant case. The PPC formed the view that Dr Rogers' convictions were sufficiently serious for there to be a possibility of erasure. Accordingly, the case was referred to the PCC.
- 23.14 This represented a new approach to convictions for drug-related offences. Instead of being referred into the voluntary health procedures, where the focus would be entirely upon rehabilitation, the case was – quite appropriately – to receive the detailed attention of a PCC panel, which would have all options, including erasure and referral to the HC, available to it. Not only that, but the hearing would be in public.

Dr JO 09

- 23.15 At the same meeting in November 2002, the PPC had to consider the case of Dr JO 09. He was a locum senior house officer. The previous year, suspicions had arisen at hospital A that he might be stealing pethidine but there was no proof of it. He moved to hospital B where it was noticed that he was apparently using pethidine on a number of patients in circumstances where it would not be usual practice to do so. On one occasion, the doctor was seen to swap syringes shortly before injecting a patient. He injected some of the liquid (which was supposed to be pethidine) and gave the syringe to a nurse with instructions to discard the remaining contents. She did not; instead she sent the liquid for analysis and it was found to be water. The doctor had stolen the pethidine he had prescribed (probably unnecessarily) for the patient and had injected the patient with a small quantity of water. The doctor was not reported to the police. I pause to observe that, when offences of dishonesty are discovered within NHS organisations, they are often not reported to the police. However, the doctor was reported to the GMC.
- 23.16 At the GMC, there was a difference of view between the screeners as to how the case should be handled. The health screener thought that the voluntary health procedures were appropriate but the medical screener wished to keep open the possibility of conduct proceedings. The GMC sought advice from its solicitors as to how it should proceed. The solicitor advised that the case should be referred to the PPC so that it could consider the medical reports and decide down which route the case should go. The case was referred to the PPC and also to the Interim Orders Committee (IOC), which imposed conditions on the doctor that would last for a period of 18 months. That was the maximum period for which the IOC could impose conditions. It often applied the maximum period, so that the

order would cover the time that might elapse before the case could be dealt with substantively. The conditions on Dr JO 09 required him to remain under medical supervision, to refrain from self-medication, to restrict his medical practice to supervised posts in the NHS, not to work as a locum and to notify his supervising consultant or any prospective employer of the conditions under which he was practising. At its next meeting, the PPC adjourned its decision and ordered medical examination by two psychiatrists.

- 23.17 The medical reports were ready for consideration at the PPC meeting in November 2002. The first psychiatrist said that there was no need to refer the case into the voluntary health procedures; the existing restrictions imposed by the IOC were sufficient. He suggested that the doctor should undergo random testing for drugs. The second psychiatrist considered that the doctor was fit to practise subject to the restraints currently imposed by the IOC. There was no need to restrict his prescribing rights. The PPC **'noted the allegations'** against the doctor, which were of theft, forgery of prescriptions and, in respect of the incident I described, depriving a patient of pethidine after it had been prescribed. It noted that both psychiatrists instructed by the GMC considered that the doctor required supervision. A further report from the psychiatrist who was treating the doctor stated that he was making good progress and was not using drugs of any kind. Somewhat surprisingly, in the light of the decision taken on the same day in the case of Rogers, the PPC decided that the case should not be referred to the PCC for inquiry. It decided instead that the doctor should be referred into the voluntary health procedures, saying that **'there was no public interest argument for referring the allegation to the PCC'**. So, in that case, the usual practice of referring cases of this type into the voluntary health procedures was followed.

A Comparison of the Two Cases

- 23.18 It is of course axiomatic that decisions of the PPC must turn upon the facts of the individual case. I also recognise that, from the papers available to the Inquiry, it may not be possible for me to make such a detailed assessment of a case as is possible for the PPC. However, the GMC should aim for broad consistency of treatment between cases of a similar type and gravity. I shall now seek to compare and contrast the cases of Rogers and of Dr JO 09, in an attempt to understand why the same constitution of the PPC reached different decisions in respect of these two cases.
- 23.19 One criterion for the PPC must always be the seriousness of the doctor's misconduct. An analysis of the misconduct of these two doctors shows great similarities. Assuming, as we must for present purposes, that Dr JO 09 would have been found guilty as charged by the PCC, both he and Dr Rogers had obtained controlled drugs of Class A by dishonest means. Both had done so, not on an isolated occasion, but over a period of time. The mechanisms by which they achieved their ends were different, but those differences were accounted for by the circumstances in which they worked. A doctor working in a hospital can take opportunities to steal drugs that have already been prescribed and dispensed. He or she may also have access to a drugs cupboard or store and be able to steal from stock. A GP cannot usually do that. GPs who obtain drugs illicitly generally do so by false prescribing. So the methods used by Dr Rogers and Dr JO 09 were different but both doctors had behaved dishonestly. It is not possible to say whether the amounts of the drug

involved in the two cases were different but, that consideration apart, the gravity of the misconduct was, to my mind, very similar. There was an additional factor in the case of Dr JO 09 that was not present in the case of Dr Rogers. It was alleged that Dr JO 09 might have deprived a patient of a drug that s/he needed. There was also a suggestion that the patient had been subjected to an unnecessary injection, which, if true, might have amounted to a criminal assault. Certainly, it appeared that Dr JO 09 was prepared to involve patients in a way that did not arise in Dr Rogers' case.

- 23.20 An examination of the medical evidence available shows that both doctors had a problem of drug dependence. In both cases, their misconduct was said to be related to the dependence. Although the reports in the case of Dr JO 09 appeared to focus in greater detail on rehabilitative measures, there was no reason, so far as I could see, to suppose that Dr Rogers was not capable of rehabilitation.
- 23.21 So far, it is difficult to see why one case gave rise to a possibility of erasure and must therefore be referred to the PCC and the other did not. However, there were some differences between the cases. One difference was that Dr Rogers had been convicted in the courts and his misconduct was, therefore, already proved. Dr JO 09's guilt had not yet been proved; that would have been a matter for the PCC to decide. However, there appears to have been no shortage of evidence and, from the medical evidence, it appears that the doctor had accepted that he had a drug problem. The fact that there was proven misconduct in one case and not in the other could not justify different treatment. Another possible difference that might have been present in the minds of the PPC is that, because the case of Rogers had been aired publicly, he had brought the profession into disrepute. Dr JO 09 had not, because his alleged misconduct had not been reported to the police. But that difference could surely not justify the different treatment of these two doctors. The fact that the hospital authorities had chosen not to make a report to the police was Dr JO 09's good fortune, but it did not mean that his misconduct, if proved, was any less serious than Dr Rogers'. In short, I cannot see how a proper analysis of the relevant issues in these two cases could have led to such different treatment.

The Outcomes

- 23.22 I turn to consider the two eventual outcomes. Dr JO 09 was referred into the voluntary health procedures. The allegations against him were never fully investigated and important issues were never resolved. We do not know whether or not he was guilty of the alleged misconduct. All the GMC proceedings took place in private. Dr JO 09 was not subjected to the stress and potential public disgrace that would have followed if, on referral to the PCC, he had been found guilty of the alleged misconduct. He entered the voluntary health procedures and restrictions were imposed on his practice. These were designed to protect the public and to facilitate the doctor's rehabilitation. There is no evidence to suggest that, in his particular case, the conditions imposed did not provide adequate protection for the public.
- 23.23 Dr Rogers came before a PCC panel, which decided to erase his name from the medical register. In giving its reasons, the panel noted that the doctor had been suffering from a depressive illness at the time of his offences. It is clear from the case report that there was

a medical opinion that the doctor's offending had been **'secondary to his illness'**. Nevertheless, the PCC panel said that it had formed the view that the doctor's current state of health was not sufficiently impaired to warrant referral to the HC. The panel then turned to discuss the seriousness of his conduct, in particular his dishonesty. It said:

'The Committee acknowledge you have not been subject to GMC procedures prior to this hearing. However, these factors do not detract from your inexcusable and dishonest behaviour. The Committee take a grave view of dishonesty in whatever form and disapproves of any action that undermines public confidence in the profession or compromises the trust that patients place in doctors. They have therefore been bound to consider most carefully whether the public interest demands that they should take action in respect of your registration.'

- 23.24 The PCC then considered the suitability of the less serious sanctions available to it and decided that Dr Rogers' name must be erased. I pause to observe that, if Dr JO 09 had been found guilty as alleged, the words cited above would have been just as apposite to him as they were to Dr Rogers and, if a grave view should be taken of **'dishonesty in whatever form'**, then a grave view should also have been taken of the allegations of dishonesty against Dr JO 09.
- 23.25 Dr Rogers appealed to the High Court on three grounds. All failed and only two are of interest in the present context. The first ground related to the way in which the PCC panel had dealt with the health issues. The Judge, Mr Justice Mitting, held that the panel's decision not to refer the case to the HC had been taken at too early a stage of its deliberations. The Judge observed that, following the decision in the case of Crabbie, the PCC should not have considered a referral to the HC until after it had ruled out erasure as an appropriate sanction. It had in fact considered (and decided against) referral to the HC before considering erasure or any other sanction. However, the Judge held that this error had not vitiated the panel's decision because it was clear that its reasons for imposing erasure were that the offences were so grave that the public interest demanded nothing less.
- 23.26 Dr Rogers also contended that erasure was too severe a sanction and was disproportionate to the gravity of his offences. The Judge upheld the PCC's reasoning on that issue. He noted the PCC panel's view that dishonesty was always serious in a doctor, especially where it undermined the trust placed in the doctor by the community. He drew attention to the various aggravating features of the case: not only were these offences of dishonesty, they involved Class A controlled drugs; they were not isolated offences; they were not peripheral to the doctor's professional duties – indeed, they were committed in the course of his professional duties. I pause to observe that every one of those aggravating features was present in the allegations against Dr JO 09. Both cases involved a breach of trust. The Judge also mentioned the mitigating factors in Dr Rogers' case, the absence of any previous record and the effect of the illness. He observed that the PCC panel had had to carry out a balancing exercise. It had not erred in law in reaching its conclusion. Indeed, Mitting J expressly stated that he agreed with the view of the PCC

panel. It must be assumed that the GMC also agreed with the PCC panel's decision. It had sought to uphold it on appeal.

- 23.27 Mitting J summarised the gravity of Dr Rogers' case by saying that the offences demonstrated a clear abuse of the trust that is placed in any medical practitioner and a breach of the principles of good medical practice. He said that such conduct inevitably undermined the confidence which members of the public place in the profession. In my view, exactly the same could be said of the conduct of Dr JO 09, if proved, and of the conduct of Shipman and of countless other doctors who have, over the years, been referred privately into the voluntary health procedures.
- 23.28 It is not for me to say that the decision in Rogers was right or wrong. I seek only to draw attention to the different ways in which these two cases were handled and to the potential unfairness which can arise if the GMC does not have clear criteria for taking decisions. The November 2002 Screeners' Handbook contained advice about the effect of the judgement in Crabbie. How great an effect that advice had on screeners (and on the PPC) is not clear. The Inquiry has not conducted an audit of cases but it appears that many doctors (save for a few like Dr Rogers) reported to the GMC for convictions for dishonesty associated with drug abuse during 2002, 2003 and early 2004 were dealt with under the old practice and were referred into the voluntary health procedures rather than being referred to the PCC. Yet, as soon as the new procedures are operative, it is intended that such doctors will be, as they should be in my view, referred to a FTP panel.
- 23.29 It appears to me that some general lessons can be learned from consideration of these two cases. The GMC has now recognised that doctors reported to the GMC for convictions arising out of drugs offences must be referred to a FTP panel. A definite instruction is to be given to that effect. However, allegations of conduct of that kind cannot be dealt with by rule of thumb. There must be individual consideration of the allegations and the evidence available to support them. What in my view must be made plain to decision-makers is that cases such as that of Dr JO 09 must not be referred into the voluntary health procedures without there having been any resolution of the factual issues. Allegations of misconduct should be determined, if not admitted, so that there can be a proper assessment of the seriousness of the doctor's misconduct. Only then can a decision be taken as to whether, in the light of the medical evidence available and any other features in aggravation or mitigation, the doctor should be erased or suspended from the register or should be allowed to practise subject to conditions. Only then will any subsequent hearings involving the doctor be able to proceed on the basis of known facts rather than a medical history.
- 23.30 Second, these two cases underline the need for clear criteria to be developed for decision-taking. As I have shown, it is hard to detect any rational basis for the distinction drawn between them. I am concerned that the difference of treatment was due to the fact that in one case the doctor's misconduct was already proved and in the other it was not. Also, it appears that considerable weight was attached to what the Judge had said when imposing sentence in the criminal court. What the Judge said was very sensible and appropriate but it seems that it served to underline to the GMC the seriousness of the case of Rogers. There was no equivalent statement in the case of Dr JO 09.

23.31 Third, in my view, allegations of misconduct such as arose in these two cases should be dealt with in public. The public has a legitimate interest in knowing what the doctor has done and what the GMC has decided to do about it. In my view, the GMC is failing the public if it deals with such cases in private. Moreover, the interests of the profession and of the GMC itself are better served by openness of treatment. Of course, the doctor is entitled to medical confidentiality. This can be achieved if the FTP panel considers the medical evidence in full but makes only brief reference to it in giving the reasons for its eventual conclusion.

The Limited Relevance of the Sentence Passed by the Criminal Court in a Conviction Case

23.32 In the case of *Rogers*, to which I referred above, the Judge had imposed a suspended sentence of imprisonment. He plainly took a serious view of the case. It is possible that the fact that the doctor's conviction had been met with a sentence of imprisonment was a factor which caused the PCC panel to take the course it did; this was not a factor which was mentioned in the panel's decision, so I mention it as a possibility only.

23.33 It does appear that, in the past, the GMC's assessment of the seriousness of the doctor's misconduct, in cases where doctors have been convicted of controlled drugs offences, has been strongly influenced by sentence imposed by the criminal court. There has been little attempt to assess seriousness from the point of view of the impact or potential impact of the misconduct on the doctor's practice. In Chapter 16, I observed that, when Shipman's convictions were reported to the GMC in 1976, the Registrar, Mr Martin Draper, would not allow the case to go to the PeCC until precise information was available about the amount of the fine and compensation orders imposed by the Magistrates' Court. However, there was no investigation into the effect that Shipman's drug abuse and dishonesty had had upon his clinical practice. That was typical of the way in which the GMC investigated such cases.

23.34 In my view, the sentence passed by the criminal court is of very limited relevance to the seriousness of the doctor's misconduct from the point of view of the GMC. I can see that, as a very broad guideline, if the judge imposes a sentence of immediate imprisonment, it is reasonable to treat the case as serious. However, the converse should not be assumed. The fact that the court has imposed a very low penalty or even none at all should not lead the GMC to the conclusion that the case is not serious in the context of GMC proceedings. The GMC should, of course, pay heed to the factual findings of the court and/or to the factual basis for the sentence imposed. However, the role of the GMC in protecting patients involves different considerations from those taken into account by the criminal courts when passing sentence. For example, an offence of dishonesty or of indecency committed by a doctor will have implications in the context of medical practice that go well beyond the considerations that the courts will take into account. What may appear relatively trivial in the context of the general criminal law may be quite serious in the context of medical practice. The GMC should take care not to base its assessment of seriousness on the sentence passed by the court, particularly where the doctor has been sentenced by a Magistrates' Court, where the reasons for passing sentence are not always fully explained. It must also be borne in mind that the court might have imposed a more lenient sentence than would otherwise have been considered because it had been said on the

doctor's behalf that he was likely to be 'struck off' by the GMC and that his career was in ruins.

The General Medical Council's Approach to Cases of Drug Abuse

- 23.35 As I have said, in the past, the GMC's approach to drug abusing doctors has been to facilitate rehabilitation so that, once the doctor's condition is successfully treated, his/her compulsion to obtain drugs disappears and it can be expected that the doctor will revert to his/her normal patterns of behaviour. Thereafter, once a reasonable period has been allowed to pass, during which the danger of a relapse recedes, the point is reached where it can safely be said that the doctor is fit to resume unsupervised practice. The successful rehabilitation into practice of many doctors who have been through the GMC's voluntary health procedures can legitimately be used to justify the approach taken. That approach has been endorsed by Parliament in the Medical Act 1978 and in subsequent legislation. Although doctors suffering from other types of ill health are also dealt with under the health procedures, it was envisaged from the first that the procedures would be used to rehabilitate drug abusing doctors.
- 23.36 It is clear from Mr Scott's evidence to the Inquiry that the old approach is no longer acceptable. The GMC now recognises that it must have available its full armoury of sanctions when dealing with doctors convicted of drugs offences. The assumptions that used to be made, that the best course in all such cases was referral into the voluntary health procedures, has gone. I hope that the GMC will take the same view about cases in which allegations of a similar nature are made, but where, for one reason or another, there is no conviction or caution.
- 23.37 Two questions now arise for consideration. How is the GMC to investigate cases involving drug abuse so as to ensure that those who have to take important decisions on sanction have all the relevant information available? What are the criteria that should be applied when deciding upon sanction?

Common Factors in Cases of Drug Abuse

- 23.38 Before considering those two questions, it may be helpful to outline the types of misconduct which have to be considered. The facts and circumstances vary from case to case, but there are a number of features that are typical of such cases. It is common for a GP to obtain supplies by prescribing controlled drugs in the names of patients who do not need them. The doctor presents the prescription at a pharmacy and collects the drugs, telling the pharmacist that s/he will deliver them to the patient's home, but in fact keeping them back for him/herself. Shipman did that. Sometimes, the GP prescribes in the names of non-existent patients and collects the drugs from the pharmacy, purporting either to be that patient or to be acting on that patient's behalf. Sometimes, the doctor enters into a collusive relationship with a patient, prescribing more drugs than the patient needs. The patient collects the drugs and gives part of the consignment to the doctor. In some cases, the GP orders the controlled drugs from a pharmacy or wholesaler on requisition or signed order, falsely representing that the drugs are for practice stock. He or she will avoid making any entry in the practice controlled drugs register and will keep the drugs for

him/herself. Shipman did that. Doctors who work in hospitals have a greater opportunity than GPs to steal drugs from a stock cupboard. Others will prescribe drugs for hospital patients who do not need them and will take possession of the drugs when they have been delivered to the ward. Such methods were referred to in research carried out by the National Addiction Centre and published in 1991², based on examination of the medical records of all doctors who had been treated for alcohol and drug misuse at the Maudsley and Bethlem Royal Hospitals over the previous 20 years. All these methods involve dishonesty in the course of practice.

- 23.39 The facts that drug abuse very often leads to dishonesty and that dishonesty in doctors is a serious matter must not be allowed to obscure the fundamental problem caused by drug abuse. Dr Douglas Fowlie, Consultant Psychiatrist, Grampian Primary Care NHS Trust, and an eminent member of the Royal College of Psychiatrists, has had a special interest in substance abuse for many years. His evidence to the Inquiry stressed that one of the important effects of drug taking is the way in which the person's perceptions of the world and his/her general values are distorted. He said:

'It is important to be aware ... that one of the facets of an illness of dependence is a selectively distorted perception of one's own behaviour. As a dependence escalates, the priority of the individual is obtaining the next fix of the drink or the drug. This is the overwhelming priority and other factors external to this diminish in their importance. When the perceptions become distorted, a lack of insight develops, and the illness can cause a distortion of what the previously non-dependent individual regarded as right and wrong.'

- 23.40 Such distorted perception no doubt explains the behaviour of doctors who think that it is acceptable to use dishonest means to obtain drugs. It also explains the conduct of those who treat patients while under the influence of drugs or while craving another dose. Presumably, doctors who do this persuade themselves that it is acceptable for them to treat patients shortly after taking a mind-affecting drug. Their perception of their own abilities and of their patient's best interests is badly distorted. Whether such distorted perceptions persist after the dependence has ceased, I do not know.

- 23.41 The facts of some of the cases I have read demonstrate how the misuse of controlled drugs can have a direct impact on patient safety. In the case of Dr JO 09, the doctor injected the patient with water and kept for him/herself the controlled drug prescribed for the patient. I have read a report of a doctor who kept falling asleep at work, even during consultations. In another case about which I read, a junior doctor was found collapsed on a hospital ward, having injected himself with a controlled drug while on duty. Shipman collapsed on several occasions when in practice in Todmorden. This was diagnosed at the time as being due to 'idiopathic epilepsy' but was in fact a consequence of his addiction. In these cases, the implications for patient safety are highly visible. In other situations, the risks to patients are less easy to observe. However, the judgement of a

² Brooke D, Edwards G, Taylor C (1991). 'Addiction as an occupational hazard: 144 doctors with drug and alcohol problems', British Journal of Addiction, Vol 86: pp 1011-1016.

doctor must always be suspect when the craving for controlled drugs is dominant in his/her mind.

- 23.42 There can be no doubt that doctors who are misusing drugs present a substantial risk to patient safety. It seems to be universally accepted that any doctor who is thought to be taking drugs should not be allowed to practise and that any doctor who has only recently given up the habit must be supervised so that any relapse will soon be recognised.

Dishonesty in Cases of Drug Abuse

- 23.43 The element of dishonesty which is almost invariably present in this category of case also has important implications for patient safety. It is clear from 'Good Medical Practice' that the GMC regards the honesty and integrity of a doctor as being of fundamental importance. Sir Donald Irvine, President from 1995 to 2002, said at the Inquiry seminars that honesty is one of the fundamental tenets of the relationship between doctor and patient and that it is essential to the integrity of the clinical process. In his witness statement to the Inquiry, Sir Donald said that the starting point for the GMC's consideration of cases involving dishonesty must be that dishonesty amounts to a dereliction of a basic duty and constitutes serious professional misconduct; his view was that, in the absence of remarkably good reasons in mitigation, it should lead to erasure of the doctor's name from the medical register.
- 23.44 At that stage, Sir Donald was speaking about cases of dishonesty in general, not in the specific context of drug abuse. He said that there was an '**unresolved issue**' in addiction cases, where dishonesty could be said to be secondary to the addictive habit itself. He said that there was a need for wider debate on the issue of dishonesty in that context, which could be clarified by a broader consensus on sanctions to be reached between the public and the medical profession. I agree, and I hope that this Chapter may provide further stimulus for such debate.
- 23.45 This '**unresolved issue**' involves what is apparently the almost unanimous view of psychiatrists from whom the Inquiry received evidence that dishonesty in the context of drug abuse is 'all part of the illness' and a natural concomitant of the abuse. In Chapter 16, I explained this belief and quoted the evidence of Dr Fowlie. Briefly, the theory is that dishonesty in the context of drug addiction in a doctor is not indicative of a fundamentally dishonest personality. On the contrary, the need to obtain the drug of addiction is so overwhelming that it becomes a compulsion and the person, who would normally be quite honest, behaves dishonestly only for the purpose of obtaining drugs. If the drug dependence is cured, the dishonesty will disappear.
- 23.46 The Inquiry wished, if possible, to explore how far that theory could properly be taken. Should it apply in all cases? If not, in which cases should it not apply? These questions were to some extent prompted by consideration of the case of Shipman. He acted dishonestly in order to obtain pethidine in the 1970s. When his misconduct had been detected, he was treated and cured of his dependency. Yet, as I found in my First Report, Shipman remained deeply dishonest after that time. In the First Report, I described a number of the ways in which this manifested itself. He used many dishonest methods to obtain diamorphine with which to kill his patients. He frequently lied to the families of

patients about the circumstances of the deaths of those he had killed. He made false entries in patients' medical records to provide natural explanations for the deaths he had caused. Those acts of dishonesty were related to the killing of patients. But he was dishonest in other contexts too. In the immediate aftermath of the discovery of his drug dependence in 1975, he was deceitful in a job application. He did not tell the Durham Area Health Authority that he was facing prosecution when applying for a post in child health. He disclosed his conviction only because he was advised to do so by the consultant psychiatrist who was treating him and did so only after he had been offered the job. Of course, I accept that Shipman's may have been a completely exceptional personality. However, his case does justify asking the question whether there is a risk that the dishonesty practised to feed a drug habit is likely to endure beyond the end of that habit. Does the risk that such dishonesty will continue render the doctor permanently untrustworthy and unfit to practise as a doctor?

- 23.47 One witness suggested to the Inquiry that, once a person has resorted to dishonest conduct – especially if that conduct has been repeated on several occasions – it may become a habit or 'life-skill' and s/he may be dishonest again in other contexts in the future. The thinking was that, once a doctor has been dishonest in order to obtain drugs, s/he cannot be trusted in future and is, therefore, generally unfit to practise medicine, at least without close supervision. It is suggested that such a person, when faced with a clinical situation requiring probity and integrity, could not be relied upon to display those qualities. If s/he makes an error, for example, s/he would be more likely to seek to cover up what had happened than to be open about it. This may be correct but there is no evidence to suggest that it is. At one stage in the Inquiry, I thought it would be useful to focus attention on dishonesty in the context of drug abuse by doctors. Having heard all the evidence, I no longer think it will be profitable to do so. Dishonesty, it seems to me, is only one component of the dysfunctional character of the drug abusing doctor.
- 23.48 Because Shipman was a known case of a person who did not fit the generally accepted theory that dishonesty will disappear when dependence is cured, it occurred to me that there might be other exceptions to that rule and, if so, it would be important to be able to recognise them, in other words to recognise those doctors in which dishonesty is just a concomitant of drug abuse and those in which it is more deeply rooted. Those doctors might be regarded as unfit to remain as doctors.
- 23.49 In considering how far the basic theory about dishonesty can be taken, it appears to me that there are a number of important questions to ask. Does the manner in which the dependence develops have any bearing on the extent to which the dishonesty will resolve when the dependence is cured? It seems to me that it might. There must be a stage at which the doctor begins to take a drug but is not yet addicted to or even dependent upon it. If the means used at that stage are dishonest, can it be said that the dishonesty is a concomitant of dependence? It would seem to me that it cannot. I recognise that some doctors suffer from organic illnesses for which they are prescribed strong analgesic drugs, sometimes including opioids. They should not become addicted to those drugs if their consumption is properly supervised, although it may be that some do. I suspect that there are few doctors (or people) who become addicted in such circumstances. There will also be some cases in which the doctor self-medicates

unwisely in the context of a psychiatric disorder such as depression. I can see how, in the context of illness, the doctor's judgement may be affected and s/he may not take the sensible course of seeking independent medical advice. There will be other cases where self-medication begins during a period of personal distress resulting from an experience such as bereavement or marriage breakdown. In such cases, the doctor's control mechanisms have broken down and s/he may stray into behaviour which, in ordinary circumstances, s/he would recognise as wrong and would avoid. I imagine that some doctors in that kind of situation begin to self-medicate with something like a benzodiazepine and that some then 'graduate' onto more addictive drugs such as opioids. I must confess that I find it quite hard to accept that there is any excuse, in that kind of situation, for a doctor to progress to the self-medication of opioids. However great the personal distress, I would have thought that any doctor who is not actually ill would recognise the danger of stepping over that line and into conduct which is not only inappropriate but also almost bound to entail dishonesty.

- 23.50 In addition to those cases where there is a more or less understandable explanation for the commencement of the habit, it seems to me that there must be a number of cases where there is no satisfactory explanation for the doctor beginning to take drugs. Nowadays, quite a lot of people take drugs for recreation. In those cases, there must be a 'lead-in' period where the doctor is exercising 'free will' in deciding to 'experiment' with drugs. His or her judgement is not at that time overborne by craving. It seems to me that a doctor, who should know of the dangers of taking addictive drugs, should not simply be regarded as an innocent 'victim' of the drug. I would have thought it unwise to assume that doctors who were prepared to obtain drugs by dishonest means at a time when they were not yet dependent would necessarily revert to honest behaviour when cured of their dependence. I also suspect that many drug abusing doctors, having been 'found out', advance false explanations of the circumstances in which their dependence began. They seek to provide an 'acceptable' explanation for their dishonest behaviour. In my view, the circumstances in which the doctor became addicted are always worthy of exploration.
- 23.51 Second, the depth or strength of the dependence or addiction may vary greatly. I accept that some are so deeply affected that obtaining their 'next fix' becomes an obsession which drives out all other thoughts. However, in many of the cases I have read, the doctor was not addicted to that extent. Shipman was a case in point. He was able to give up using pethidine at times. For example, when he went away on holiday it appears that he managed without it. I have seen medical reports in which it is said that he was 'habituated' to the drug but not deeply addicted. Dishonesty in such cases cannot be explained on the grounds of compulsion or irresistible craving.

Evidence Obtained by the Inquiry

- 23.52 To assist with the understanding of the issues surrounding drug abuse in doctors and how the GMC should deal with it, the Inquiry obtained expert evidence from Dr Andrew Johns, Consultant Forensic Psychiatrist, South London and Maudsley NHS Trust, who has considerable experience in the psychiatry of addiction. Dr Johns' evidence dealt with the issues of substance misuse by doctors, the risks posed by a rehabilitated doctor, the likelihood of relapse into drug taking and assessing the risk of relapse. His views were

similar to those expressed by Dr Fowlie. Dr Johns said that 'dishonesty' is not a fixed personality trait but is a form of behaviour which could be used to achieve a range of diverse ends and which could have a range of causes. He said that it would be a mistake, therefore, to suppose that dishonest behaviour by an individual in one context necessarily predicted dishonest behaviour by that individual in an entirely different context. Once the drug addiction is treated, the 'imperative' to forge prescriptions or to steal drugs is substantially reduced. A number of participants at the seminar agreed with that view.

- 23.53 Dr Johns said doctors with drug and alcohol problems who receive appropriate treatment 'do well'. He referred to data from the USA, cited in the 1991 paper to which I referred in paragraph 23.38, which showed that, with proper rehabilitation, 75% of such doctors were practising and drug-free at follow-up periods of between two and eight years. The data demonstrates a creditably high success rate for the treatment of drug abusing doctors. However, it also means that no fewer than 25% of doctors returned to drug taking within eight years.
- 23.54 Dr Johns said that it would be extremely difficult to assess the risk of future criminal behaviour in an individual case of a drug abusing doctor because of the difficulties in predicting human behaviour. He said that a risk factor could be anything which had a statistical association to a future event and, although steps could be taken to analyse risk, it could not be accurately predicted. He said that he did not have any personal experience of a doctor whom he had treated for drug misuse and who had later been discovered to have committed a criminal offence. He said that he suspected that the proportion of doctors who, having committed an offence of dishonesty in connection with drug misuse, went on to commit a further offence of dishonesty was extremely low. I think he was referring to doctors other than who relapsed into drug taking. I do not think he was asserting that the incidence of further dishonesty was low; I think he accepted that he would not usually be aware of what happened to his patients after they had been discharged from his care.
- 23.55 At the Inquiry's seminars, Dr Fowlie repeated and enlarged upon what he had said in his witness statement. He said that, during treatment for the addiction, 'clarification' of the dishonest behaviour is an 'important therapeutic weapon'. If the individual is able to confront his/her dishonest behaviour, that is, he said, a good prognostic indicator. I take that to mean that the prospects for full and permanent rehabilitation are enhanced if the doctor has fully accepted that s/he was dishonest and that this dishonesty was unacceptable. The converse might well suggest that doctors who continue to make false excuses for themselves (such as 'I started to self-medicate because of a back injury' – which was an explanation advanced by Shipman) are less likely to do well.
- 23.56 This evidence seems to me to point to two conclusions. First, even if a drug abusing doctor is treated and appears to have been rehabilitated, there is a risk of relapse of the order of 25% over a period between two and eight years afterwards. It may be that more research should be undertaken into the incidence of relapse among drug abusing doctors. Second, the extent to which dishonesty associated with drug abuse may be 'excused' as being a part of the illness and may be expected to resolve once the dependence has been cured may depend upon at least two factors, the strength or depth of the addiction and the extent

to which the doctor has fully understood and 'confronted' his/her own dishonesty. Putting forward false excuses for how it all started might be a bad indicator.

What Should the General Medical Council's Approach Be in Drug Abuse Cases?

- 23.57 Throughout the period examined by the Inquiry, the GMC has focussed upon obtaining medical evidence to ascertain whether and how the doctor's drug abuse was being treated and upon the prospects for rehabilitation. That approach should now change, in my view. I consider that it is essential that certain findings be made about the circumstances of the abuse. These findings must be made even in cases in which the doctor has been convicted of offences and his/her misconduct is therefore proved.
- 23.58 First, if the allegation of drug abuse is disputed, there must be a proper resolution of the dispute and the facts must be found. They must not be fudged. I was told that, in the past, if a doctor gave the voluntary undertakings required by the health screener, this would be regarded as an acknowledgement by the doctor that s/he did at least have a drug problem. I can understand why that short cut to the voluntary health procedures must have seemed attractive. It avoided the time and cost of an investigation, as well as the risk of a finding that the doctor was 'not guilty'. However, the effect of taking such a course was that there were then no findings about the misconduct, if any, of which the doctor had been guilty. There was no assessment of the seriousness of that misconduct or of its implications for patient safety. It appears to me that it is almost impossible to form a proper view about whether a doctor is fit to practise medicine if serious allegations against him/her are left unresolved in this way.
- 23.59 Second, if it is found or admitted that the doctor has been abusing drugs, it should not be assumed that s/he has been the unfortunate victim of circumstances beyond his/her control. The GMC must attempt to find out when and how the abuse began. The doctor's explanation of how s/he came to be addicted should be subjected to careful scrutiny and the story should be checked by consulting with people who were in contact with the doctor at the material time and, if appropriate, by examining medical records. The GMC should find out for how long the abuse has persisted and by what means the doctor obtained the drugs. It must discover what deceptions were practised and upon whom. There should be a proper assessment of the depth or strength of any addiction or dependence. If the doctor was able to manage without drugs at will or if s/he was withdrawn from them with more than usual ease, the conclusion might be that the doctor was not fully addicted. If so, the inference might be that the doctor was not subject to an overwhelming compulsion to obtain supplies and the decision-makers should be less ready to overlook any dishonesty of which the doctor has been guilty.
- 23.60 Third, there should be an examination of the way in which the doctor's practice was affected. Were patients involved in the obtaining of drugs? How did the doctor behave while addicted? Was patient care affected? This kind of information might well affect the decision on sanction. In particular, if conditions were thought appropriate, such information would help the GMC to devise appropriate conditions. This kind of information would be gathered from the doctor's colleagues and would have an additional beneficial

effect in that it would enable the colleagues who would be responsible for the welfare of patients to identify those patients who had been at risk.

- 23.61 Finally, if and when it was suggested that the doctor was rehabilitated, there should be some assessment of the extent to which the doctor had regained insight and had fully accepted the seriousness of what s/he had done. In some of the medical reports I have seen, the psychiatrist has addressed that issue; in others, that factor does not seem to have been considered and the emphasis is on the period of time for which the doctor has been able to abstain from drugs. I am not saying that that is not important; it is, but there should be other considerations as well.
- 23.62 Undoubtedly, an assessment of the doctor's health will be required and to that end one or two psychiatric reports will be required. However, the investigation of background factors should not be left to the psychiatrists. It would be unreasonable to ask them to undertake the kind of investigations that I am advocating. It may be necessary to examine patient and/or practice/hospital records, including the doctor's own medical records. It may also be necessary to interview the doctor's colleagues, practice staff and patients. These enquiries should be carried out by GMC investigators and the information gathered should be shared with the psychiatrists, as it may affect their opinion. For that reason, it will usually be inappropriate to accept a report from the doctor's treating psychiatrist; s/he may not wish to delve into background matters in the way in which I am suggesting that the GMC should do. If all these steps are taken, the evidence should shed greater light on the risks that the doctor's drug abuse has presented in the past and may present in the future.

Conclusions

- 23.63 It appears that the case of Crabbie triggered some reconsideration within the GMC as to how doctors convicted of drug offences should be dealt with. Mr Scott, at any rate, fully understood its implications in respect of convictions and I am sure that the GMC will have appreciated that those implications extend to cases in which unproven allegations of a similar nature have been made. The GMC has issued draft guidance that should ensure that doctors convicted of drugs offences will, under the new procedures, be referred to a FTP panel.
- 23.64 I have explained how cases of drug abuse should be investigated before they reach a hearing. These investigations must take place in both conviction cases and those involving an as yet unproven allegation. If those investigative steps are taken, the FTP panel will be in a much better position than decision-makers have ever been in in the past to decide whether the case warrants erasure or suspension or whether the imposition of conditions will be appropriate and will adequately protect the public and patients.
- 23.65 There is a thread running through many of the Chapters of this Report that deal with the GMC. It is that, if the GMC is to achieve an acceptable degree of consistency (and predictability, as doctors should know what is likely to happen to them if they transgress), it must establish some agreed standards, criteria and thresholds. By 'agreed', I mean not only agreed within the GMC (although that would be helpful), but agreed between the

GMC and the public. There must be public discussion and debate about what is the right response to, and the right sanction for, the types of case that come up again and again. Doctors who commit drug abuse are but one example of the problem. Until this work on standards, criteria and thresholds is done, there will be continued dissatisfaction with, and criticism of, the GMC.

- 23.66 It is not for me to dictate how this should be done. I have suggested as one option a method of debate and consultation similar to that of the Sentencing Advisory Panel. In the case of Rogers, Mr Justice Mitting suggested that reports of cases of that kind should be collected so that it would be possible to see in which types of situation other PCC panels (or judges) had thought erasure or suspension or conditions were appropriate. I agree that this should be done, although at the moment there are virtually no such decisions available. As such cases go through to FTP panels and decisions are made, they should, in my view, be collated into a body of case reports, available for future reference. That would serve two purposes. It should help to provide a measure of consistency between similar cases but it should also form a factual basis on which consultation could take place about what sanctions are appropriate in different types of case.
- 23.67 There should also be a debate within the GMC about the nature of the conditions that should be imposed when it is thought appropriate that a doctor who has been abusing drugs should be allowed to continue in practice. In the past, decisions about conditions have usually been taken by health screeners, who developed a good deal of expertise. In the future, such decisions will be taken by FTP panels and, where voluntary undertakings are concerned, by case examiners assisted by GMC staff. In any event, some very clear guidance will be necessary. I also consider that it would be beneficial if further research were to be done into the relapse rate of doctors who have been through the GMC health procedures. The American research quoted by Dr Johns suggests that there remains a significant risk of relapse after the two-year drug-free period which, in the past, the GMC has taken as a rough guide as to when a doctor should be allowed to resume unrestricted practice. It may be that the GMC health procedures have a greater success rate than the American methods. I do not know but I think that the GMC should find out. This could affect the length of time for which supervision is thought to be necessary.
- 23.68 In my Fourth Report, I discussed the power granted to the Home Secretary under section 12 of the Misuse of Drugs Act 1971 to direct that the right of a medical practitioner to prescribe controlled drugs should be removed or restricted. In recent years, this power has fallen into disuse. It appears that the view has been taken that the GMC is better placed than the Home Office to assess the need for such restrictions to be imposed. I was told that the repeal of section 12 was under consideration. I recommended that, before taking any decision on the repeal of section 12, the Home Office should commission a review of the use which the GMC makes of its power to impose prescribing restrictions on doctors. From the cases that I have examined, I have the impression that the GMC does not often impose a condition preventing a doctor from prescribing or possessing controlled drugs. I repeat that there should be a review of the cases in which such restrictions are imposed.