

## CHAPTER FOUR

### The Authority of a Medical Practitioner to Prescribe, Possess, Supply and Administer Controlled Drugs

#### Introduction

- 4.1 In the preceding Chapter, I have set out a brief historical background to the authority of medical practitioners to prescribe, possess, supply and administer controlled drugs. In this Chapter, I shall deal with a number of issues that arise from this authority.
- 4.2 The Misuse of Drugs Regulations (MDR) 2001 provide that doctors, acting in their capacity as such, may possess any controlled drug (save those in Schedule 1 to the MDR 2001), and may supply it to anyone who may lawfully possess it. That is subject to the rule that I mentioned in Chapter Three, to the effect that only doctors who have been specially authorised may prescribe, supply or administer cocaine, diamorphine or dipipanone for the treatment of addiction. Accordingly, any doctor who is registered with the General Medical Council (GMC), and who is not subject to any prescribing restrictions, has the general freedom to prescribe, possess, supply and administer controlled drugs. This is subject to the safe custody requirement and the requirement to keep a controlled drugs register (CDR), which apply to the stocks of some controlled drugs held personally. Doctors may lawfully prescribe any controlled drug (other than a Schedule 1 drug) in any quantity or strength, on either a private or a NHS prescription. The medical register kept by the GMC includes retired doctors, doctors who work in purely administrative posts, doctors who work in the pharmaceutical industry and doctors whose area of specialism may never require them to prescribe controlled drugs. In Chapter Three, I mentioned that, in the 1920s, it was suggested that only doctors **'in actual practice'** should be entitled to prescribe controlled drugs but this limitation was never enacted.

#### Guidance to General Practitioners on Good Practice in the Prescribing of Controlled Drugs

- 4.3 General practitioners (GPs) prescribe controlled drugs in a wide variety of situations. Schedule 2 drugs, which include the opiates such as diamorphine, are commonly used in the care of patients with terminal illness. The use of diamorphine for the relief of acute cardiac pain has decreased as a result of the improved care provided by the ambulance service. Nonetheless, there remain a wide variety of circumstances in which a GP might need to prescribe or use a controlled drug.
- 4.4 Only a minority of doctors (e.g. those working in the fields of addiction or palliative care) have received any specific training in the prescribing of controlled drugs or in their duties in relation to the Misuse of Drugs Act 1971 (MDA 1971) and the MDR 2001. However, some guidance on good practice is available. In 1999, for example, the Department of Health updated its 'Drug Misuse and Dependence – Guidelines on Clinical Management', previously issued in 1991. This document affirms that a doctor has an ethical responsibility to treat all patients and that GPs treating individuals for drug misuse have a right to support from their primary care organisation. It reminds doctors that treatment for addiction, when

it involves the prescribing of controlled drugs, leads inevitably to the potential for diversion of the drugs and to the consequent tension between the health imperative and the need to reduce illicit drug use.

- 4.5 In setting out the responsibilities and principles for prescribing for drug dependence, the Guidelines recommend that doctors should keep good, clear, handwritten or computerised records of prescribing. Doctors are advised to liaise with the dispensing pharmacist about each patient and his/her prescribing regime. They are also advised that no more than one week's supply of drugs should be dispensed at a time, save in exceptional circumstances. The patient should be told that methadone and other controlled drugs must be kept out of reach of children. Special vigilance is urged with regard to the security of drugs, prescription pads and headed notepaper. The requirements of the MDA 1971 and MDR 2001 are explained.
- 4.6 The GMC does not currently provide guidance specifically related to controlled drugs, although it provides general advice on prescribing in its booklet 'Good Medical Practice'.

### Problems with Controlled Drugs

- 4.7 The general freedom to prescribe reflects the desirable principle that doctors should enjoy clinical autonomy over their treatment of patients. However, it gives rise to undesirable consequences when doctors abuse that freedom and prescribe, supply and administer drugs unlawfully, inappropriately or irresponsibly. It may also give rise to a temptation for a doctor to prescribe for him/herself or for relatives and friends in circumstances where such prescribing may be unwise and not in the patient's best interest.
- 4.8 While the great majority of doctors behave honestly, appropriately and responsibly in their dealings with controlled drugs, there exists a minority which does not. Unlawful, irresponsible and inappropriate prescribing practices are damaging to the interests of patients, the medical profession and the public. In my view, it is important that any abuse of the doctor's prescribing privilege should be prevented where possible and detected and stopped when it occurs.
- 4.9 The Inquiry's focus is necessarily on doctors – GPs in particular. The law is changing, however, and some nurses and other healthcare professionals are now permitted to prescribe controlled drugs. There is no reason to believe that the problems posed by the doctor who prescribes dishonestly, irresponsibly or inappropriately will not also arise with the new categories of prescribers.

### Dishonest Prescribing

- 4.10 While in Todmorden, Shipman repeatedly obtained supplies of pethidine for the purpose of self-administration. Because he was not acting in good faith in his capacity as a medical practitioner, he was in unlawful possession of the drug. When he wrote a prescription in the name of a patient who was not going to receive the drug, he obtained possession of the drug by deception. When he signed a false name on the back of the prescription, purporting to claim exemption from the prescription charge on behalf of the patient, he

was guilty of forgery. In 1976, he was convicted of a range of offences. Every year, the courts and the GMC have to deal with a number of doctors who have behaved in a similar way. Some seek to obtain illicit supplies of controlled drugs to feed their own drug habit, as Shipman did in the 1970s. It seems likely that there will be very few indeed who, like Shipman, go on to obtain supplies for the purpose of killing patients. Some, however, make a living out of prescribing or supplying to addicts in breach of the law. The following are examples of the kind of unlawful conduct which has been brought to the Inquiry's attention.

#### *Supplying Controlled Drugs for Monetary Gain*

- 4.11 In 1998, Dr A was convicted of conspiracy to obtain controlled drugs, including Rohypnol (the so-called 'date rape' drug), by deception and to supply controlled drugs including Dexedrine and Seconal. Between January 1995 and February 1997, she wrote more than 70 private prescriptions for controlled drugs. Each prescription was for an amount that would have represented up to a year's normal supply of the drug. Each prescription was made out in the name of a different person and the drugs were collected from a pharmacy by the same third party in each case. This practice came to the attention of the police and, in interview, Dr A suggested that she habitually provided controlled drug prescriptions for her 'patients' without examining them. She did not keep any records for these 'patients'. Police enquiries failed to locate even one genuine patient. On one occasion, according to press reports of her trial, Dr A had written three bogus prescriptions and had received £250 in cash for each prescription. Evidence in the case suggested that the price payable by the patient for each tablet was about 20 pence compared to the 'street value' of up to £5. At the time of sentencing, Dr A was 63 and was described as a semi-retired GP who worked in the field of drug addiction. She was sentenced to a suspended term of imprisonment.
- 4.12 In 2002, Dr B was convicted of the unlawful supply of controlled drugs, including diazepam, Rohypnol and Dexedrine. He had been prepared to issue private prescriptions for a controlled drug on payment of £30. He did not examine the 'patient' in any way. He often issued prescriptions in a false name, thereby making detection less likely. He was also prepared to sell controlled drugs such as diazepam and Rohypnol from his own supplies to callers on demand. These callers could not, in any true sense, be described as patients. In 1988, Dr B had been visited by Home Office inspectors and warned about his prescribing of controlled drugs. Dr B had given up practice as a GP in 1992 but had returned to do locum work in 1993. He was working as a salaried assistant at the time of the offences but had agreed to see some former 'patients' on a private basis at his home. Over a period of four to five months before his detection, he was seeing about 20 to 25 'private patients' a week. Most of these were addicts recommended to him by other addicts.
- 4.13 In another case, the suspicion was that Dr C supplemented his living by selling temazepam capsules. His method was to select patients who were entitled to free medication on the NHS. He would write a prescription for the medication they required and include an order for 60 temazepam capsules. He would instruct the patient to go to the pharmacy and then to bring back the medication for him to check. He would then remove

and keep the temazepam. It was found that he had done this on 16 occasions, thereby obtaining 960 capsules. At the time, these had a street value of about £3 to £4 each. In 1996, Dr C admitted his guilt and was sentenced to three months' imprisonment.

- 4.14 Another doctor, Dr D, supplied drug users with Diconal (dipipanone) tablets, methadone mixture and temazepam capsules and tablets. He also issued private prescriptions for controlled drugs, on demand, for a charge of £10 or £15. The names and the addresses on the prescriptions were fictitious. As a single-handed practitioner, he had a very small list of patients. Drug users from surrounding areas visited him, knowing that he would be prepared to supply drugs or issue a prescription without asking questions. A total of 174 patients (half his list) were being prescribed controlled drugs. Dr D was warned about his conduct by a Home Office Drugs Inspector. Three months later, the doctor was found to be continuing in his old course of conduct. He was arrested but not prosecuted. The case was reported to the GMC and he was erased from the medical register in 1994. It was suggested by Counsel for the GMC that the doctor had acted with the intention of increasing his patient list and not with the best interests of his patients in mind.

#### *Obtaining Controlled Drugs to Feed the Doctor's Addiction*

- 4.15 It has long been recognised that the ease of access of doctors to controlled drugs gives rise to an increased risk of addiction. Doctors who become addicted to a controlled drug usually obtain their supplies either by prescribing it for themselves or by using supplies taken from the practice stock. In research carried out by Brooke, Edwards and Taylor, reported in 'Addiction as an Occupational Hazard'<sup>1</sup>, the records of 144 doctors who had been treated for drug and alcohol problems at two London hospitals were analysed. It was found that 83 of the 144 had been addicted to a controlled drug. Only four of the 83 had resorted to black market supplies. The usual means of supply were self-prescribing, prescribing for self but in the name of another, taking practice supplies and keeping 'patient returns'. On average, the doctors had misused the controlled drug for over six years before seeking treatment.
- 4.16 The Inquiry learned of several cases of GPs who had become addicted to a controlled drug and had been brought before the criminal courts. Dr E was a GP who, in 2000, pleaded guilty to six counts of unlawful possession of diamorphine, and seven counts of obtaining property by deception. Over 400 offences of a similar nature were taken into consideration. He had offended, over a period of seven years, for the purpose of feeding his own addiction. In the early days, he obtained diamorphine on requisition and took possession of unused drugs when a patient died. Later, he began to prescribe diamorphine and morphine in the names of genuine patients who, in some cases, were terminally ill. He obtained the drugs without payment by using a NHS prescription form and signing on the reverse, claiming that he was the patient's representative and the patient was entitled to free medication. All three of these methods of obtaining were also used by Shipman. Dr E was made the subject of a probation order. When the case was referred to the GMC, Dr E entered the voluntary health procedures and was allowed to

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<sup>1</sup> published in the *British Journal of Addiction* 1991; 86:1011–1016

continue in practice, subject to conditions. From 2003, he was allowed to practise without restriction.

- 4.17 Dr F was dependent on diamorphine. He obtained his supplies by writing NHS prescriptions in the names of patients and arranging for the drugs to be delivered to his surgery. The patients did not need, and did not receive, the drugs. There were no entries in the patient records. The doctor also kept and used a quantity of the controlled drug dihydrocodeine, returned to him by a patient for destruction. In 2003, he pleaded guilty to a large number of offences of deception and unlawful possession.
- 4.18 Dr G was addicted to pethidine. Using signed orders, he obtained the drug in both tablet and ampoule form from four pharmacies in the area in which he practised. After his activities had come to the notice of the police chemist inspection officer (CIO), he was interviewed by the Home Office Drugs Inspectorate (HODI). He claimed that the drugs he had bought had been used on patients. He was advised about his duty to keep a CDR. He continued to obtain pethidine on signed orders and this came to the attention of the CIO. In the course of a police interview, Dr G admitted that the drugs were for his own use. In 1999 he pleaded guilty to two charges of unlawful possession of pethidine and asked for 32 further cases to be taken into consideration. He was put on probation for 12 months.

### **Irresponsible Prescribing**

- 4.19 I have dealt so far with doctors who prescribed dishonestly and broke the law. Others abuse their privilege by prescribing drugs in a way that complies with the law but is irresponsible. Sometimes, a doctor will prescribe on the basis that s/he is treating a patient for organic disease while carelessly turning a blind eye to the fact that the patient is addicted. In other cases, the doctor will prescribe in quantities far in excess of those reasonably needed by the patient, who then sells the excess on the black market to finance his/her next supply. Private patients have to pay for the prescription, as well as for the drugs, and will sometimes sell part of their supply in order to finance their next prescription. Patients will sometimes obtain supplies from more than one source (e.g. from one doctor on the NHS and from another privately), a practice known as 'double scripting'. There is no legal duty on a doctor providing a private prescription to ascertain whether the patient is already receiving drugs on the NHS or whether s/he can afford to pay for the prescription and the drugs to be dispensed. Connivance with, or turning a blind eye to, this kind of conduct is irresponsible. Mr Stephen Lutener, former Head of Professional Conduct of the Royal Pharmaceutical Society of Great Britain (RPSGB), said that such practices cause considerable problems in London, where most private GPs practise.
- 4.20 The Inquiry heard about a number of such cases. Typically, the doctor would be prescribing prescriptions for controlled drugs for 'patients' who attended the surgery but who were not receiving real medical attention. A fee would be charged but there would be virtually no examination of the 'patient' and no records would be kept. Nor would the doctor make any attempt to contact the usual medical practitioners of the 'patients'. There would be no clear breach of the MDR but such prescribing would be highly irresponsible.
- 4.21 Such doctors appear to make a business out of irresponsible prescribing. Others behave irresponsibly as the result of naïveté rather than bad faith. Some doctors, particularly when

old or frail, become the prey of drug addicts, who soon learn when it is possible to persuade a doctor to prescribe controlled drugs. Addicts will often approach a doctor with a plausible story about the urgent need for a controlled drug for the relief of pain. If the doctor believes the story of one addict and provides a prescription, other addicts soon learn where to go. One is bound to feel some sympathy for the doctor who unwittingly finds him/herself in a situation that might well become quite intimidating. Such cases, when discovered by the authorities, are usually dealt with by the giving of advice as to how to avoid the problem. Only the more serious cases of irresponsible prescribing would be the subject of any formal disciplinary proceedings for serious professional misconduct before the GMC.

- 4.22 The Inquiry has also become aware of concern that some doctors prescribe drugs such as benzodiazepines in larger quantities than is either necessary or appropriate. Guidance was issued by the Committee on Safety in Medicines in 1988, advising GPs not to prescribe these drugs for long-term use but to limit them to the short-term treatment of patients with distressing symptoms of anxiety or insomnia. The main reason behind this guidance was that it was realised that benzodiazepines are addictive and can be dangerous. However, there is now another cause for concern. It appears that some patients who receive a regular supply on prescription sell part of their stock; in effect the drugs go onto 'the street'. Although the prescribing of benzodiazepines has declined substantially since 1988, it appears that many GPs still do not heed the 1988 guidance and continue to prescribe substantial quantities of benzodiazepines over a long period. In the Chief Medical Officer's 'Update 37', issued to all doctors in January 2004, he estimated that 14% of substance misusers attending drug treatment centres reported benzodiazepine use subsidiary to their main drug use. The DoH is planning to introduce instalment dispensing of benzodiazepines for addicted patients in order to minimise access to large quantities.

### Unwise Prescribing

#### *The Doctor Who Self-Prescribes or Prescribes for Family and Friends*

- 4.23 Although it is discouraged by the GMC, it is not unlawful for a doctor to treat him/herself or members of his/her own family. The doctor has the right to prescribe, supply or administer all controlled drugs to any person, including him/herself and members of his/her family, for the treatment of organic disease. It appears that s/he can also prescribe or administer the usual range of controlled drugs to such persons for the treatment of addiction. I have already mentioned in Chapter Three that it was proposed in the 1920s that doctors should not be allowed to prescribe controlled drugs for themselves and that the proposal was shelved in the face of opposition from the British Medical Association (BMA).
- 4.24 The legal position under the MDR 2001 is that a doctor is authorised to possess any controlled drug provided that s/he does so **'when acting in his(/her) capacity as such'**, i.e. in his/her capacity as a medical practitioner. In the leading case of *R v Dunbar*<sup>2</sup>, a doctor was convicted of the unlawful possession of a quantity of pethidine and

<sup>2</sup> [1982] 1 All ER 188

diamorphine which he had obtained from a pharmacy on a signed order, stating that it was required for 'professional purposes'. He had admitted to the police that he had obtained the drugs for self-administration. It was alleged by the prosecution that the doctor had told the police that he had obtained the drugs with the intention of killing himself but, in evidence, he denied saying that and claimed that he had obtained them in order to treat himself for depression. The trial judge directed the jury to convict on the basis that any obtaining with the intention of self-administration was unlawful. The Court of Appeal held that the trial judge's direction had been wrong. Under regulation 10(1) of the MDR 1973, a doctor who, in good faith, prescribed or obtained on signed order a controlled drug for his/her own treatment was entitled to have the drug in his/her possession. The Court of Appeal decided that the issue whether, on that occasion, the doctor had acted in good faith in his capacity as a medical practitioner (as opposed to having obtained the drug for the purpose of committing suicide or for some other unlawful purpose) was an issue for the jury to decide.

- 4.25 It should be noted that, on the facts of the case of Dunbar, there was no question of the doctor treating himself for addiction. It appears that the courts have never considered this issue. However, it seems to me that such a practice is not unlawful, although I hope that the GMC would take a serious view of it. Nor is it unlawful for a doctor to prescribe controlled drugs for members of his/her family or for friends, whether for the treatment of organic disease or for the treatment of addiction, provided that s/he is acting in good faith in his/her capacity as a medical practitioner.
- 4.26 Although that is the legal position, there are good reasons to suggest that it is unwise for a doctor to prescribe for him/herself, friends and family. The GMC, the Royal College of General Practitioners and the BMA all regard such prescribing of any drugs as poor practice. The BMA guidance on prescribing, which is not limited to controlled drugs, appears in 'Medical Ethics Today', the BMA's handbook of ethics and law (2<sup>nd</sup> edition) in the following terms<sup>3</sup>:

**'The BMA and the GMC advise doctors against prescribing for themselves or for family, friends and colleagues. There are clearly some cases, such as in an emergency situation, in which such action would be reasonable but as a general rule it should be avoided. There is a risk that doctors who self treat may ignore or deny serious health problems or may simply treat symptoms without taking steps to identify the underlying cause. There is also a risk that self-prescribing could lead to drug abuse or addiction; ...**

**Treating family, friends, and colleagues could raise questions about the objectivity of the advice provided and, although the same duty of confidentiality would apply, raises issues of privacy for the family members and friends. One-off prescribing for family and friends, except in exceptional circumstances, is also to be avoided because this could interfere with care or treatment being provided by the patient's usual**

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<sup>3</sup> published 2004 by BMJ Books



**doctor. There is also a risk that, if the patient is harmed by the medication, the doctor's motives could be called into question.'**

- 4.27 It seems clear that it is sensible for a doctor to ensure that any controlled drug required by him/herself or by a friend or family member is prescribed by a doctor who is at 'arm's length' and in a proper professional relationship with the patient. I can see that it might not be appropriate to prohibit a doctor altogether from prescribing such drugs for him/herself, family or friends. If this were not permitted in an emergency, it might give rise to unacceptable delay in treatment. However, it seems to me that such prescribing for the treatment of chronic organic conditions and, worse still, for the treatment of addiction is extremely undesirable. I shall consider in Chapter Fourteen whether and to what extent the present position should be changed.

#### *Prescribing for 'Casual' or Occasional Patients*

- 4.28 The current legal position is that there need be no formal relationship between a doctor and the patient for whom s/he prescribes controlled drugs. Accordingly, a doctor is entitled to prescribe any drug, including a controlled drug, to any patient whom the doctor is willing to see, even on an entirely isolated occasion. In most cases, there will be nothing improper or unwise about such a consultation, even when it results in the prescription of a controlled drug. However, at present, there is no way in which the doctor can readily acquaint him/herself with the patient's previous medical or drug history. In future, when (as it is intended) all NHS records will be accessible to all NHS doctors on a national electronic system (the NHS Care Record), the position will be easier. However, at present, a doctor who prescribes a controlled drug to an unknown patient, without first speaking to the patient's usual GP, risks not only prescribing something that might interact badly with other drugs being taken by the patient but also the possibility that the patient is obtaining a controlled drug from two doctors concurrently or, in other words, is double scripting.
- 4.29 In the current edition of 'Good Medical Practice', the GMC advises doctors to:

**'... prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and medical needs'.**

It seems to me that the GMC and/or the BMA might think it appropriate to include special advice in their respective guidance about the particular dangers of prescribing a controlled drug without adequate knowledge of the patient's history.

## **Powers to Restrict the Rights of a Practitioner in Respect of Controlled Drugs**

### **The Power of the Home Office to Restrict a Doctor's Rights Following Conviction**

- 4.30 In Chapter Three, I explained the historical background to the power of the Home Secretary to restrict the right of a doctor to deal with controlled drugs. In brief, since 1921, if a doctor has been convicted of certain criminal offences involving controlled drugs, the Home Secretary has had the power to make a direction restricting the doctor's right to



possess, prescribe, supply or administer any controlled drug or type of controlled drug named in the direction. The current power is to be found in section 12 of the MDA 1971. The power to make a direction does not apply where the doctor has been cautioned but not prosecuted, despite the fact that a caution cannot be issued unless the doctor has admitted an offence. Nor does the power apply where the doctor has been found guilty of an offence but has been given an absolute or conditional discharge or put on probation. In the past, the power was used to prevent doctors who were convicted of offences involving unlawful possession or supply of controlled drugs or obtaining such drugs by deception from prescribing or having any dealings with such drugs while the direction remained in force.

- 4.31 On receiving notification of a conviction, a Home Office official would prepare a case for possible submission to the Home Secretary. As part of that preparation, the Home Office would consult with the Department of Health and Social Security (DHSS) and would enquire of the GMC as to what action, if any, it intended to take upon the doctor's registration. If the GMC did not intend any positive action and if the DHSS was against the making of a direction, it would be very unlikely that one would be made, although the discretion remained with the Home Secretary.
- 4.32 It would have been open to the Home Secretary of the day to make a direction under this section against Shipman in 1976, but, for reasons that I shall explain in Chapter Ten, none was made. The Home Office provided the Inquiry with a number of files relating to cases in which section 12 directions (or directions made under previous legislation) had been made against doctors between 1969 and 1986. The evidence suggests that such directions were made from time to time until 1976, when there was a policy change. Up to that time, they were being made in cases where a doctor had, on a number of occasions, obtained a controlled drug unlawfully, whether in order to feed his/her own addiction or in order to make money through improper supply to others. However, it appears that, after 1976, as a result of the policy change, only doctors convicted of offences involving the supply of drugs to others were made the subject of a section 12 direction. Doctors who offended only in order to feed their own addiction, and in whose cases there was no evidence of any adverse impact on patients' well-being, were not subjected to any official restriction.
- 4.33 Thereafter, very few directions were made and it appears that the provision has not been used at all since about 1994; it was last used against a doctor (as opposed to a pharmacist or other healthcare professional) in 1986. Mr Alan Macfarlane, Chief Inspector of the HODI, explained that there is little point in the Home Office exercising this power now that the GMC has the power to impose conditions and restrictions upon a doctor's right to prescribe. The GMC usually becomes aware of any relevant conviction and the view is taken by the Home Office that the GMC is in a better position than the Home Office to make a decision. Few, if any, section 12 directions now remain in force.

#### **The Power of the Home Office to Restrict a Doctor's Rights by Reason of Irresponsible Prescribing**

- 4.34 As I explained in Chapter Three, it was recognised as early as 1926 that some power was needed to control the activities of doctors who abused their privilege of prescribing

controlled drugs. From 1967, the Home Secretary had the power to make a direction restricting the right of a doctor to prescribe, supply, possess or administer any controlled drug if s/he were found to be in breach of certain regulations governing the handling of controlled drugs or the terms of a licence. This power was not exercised until after the passage of the MDA 1971, section 13 of which extended it to include any doctor who was found by a tribunal to have been prescribing **'in an irresponsible manner'**. There was no statutory definition of **'irresponsible'**. During a House of Commons debate on the Misuse of Drugs Bill in 1970, the then Home Secretary spoke of the measure as being designed to deal with **'careless, negligent or unduly liberal prescribing'**. In the 20 years during which the section 13 provision was applied, it was never considered by the courts and, as a result, there was never any authoritative definition of irresponsible prescribing.

- 4.35 Setting in motion the tribunal proceedings that were a necessary preliminary to a section 13 direction was always an option of last resort for the Home Office. The first response to a suspicion of irresponsible prescribing was to contact the doctor and seek to persuade him/her to alter his/her prescribing practice. Only if such measures failed would section 13 proceedings be commenced, and the authority of a senior official was required before this could be done. The proceedings were extremely cumbersome. Mr Macfarlane described the process as 'tortuous'. The Home Office was, in effect, the prosecutor of the proceedings before the tribunal. Preparation of the evidence and making the arrangements for a hearing might well take up to a year. When a date had been set, there were often adjournments for one reason or another. Why the processes of evidence gathering and setting a date should have taken so long is not clear but the evidence to the Inquiry was that they did.
- 4.36 When the case eventually came before the tribunal, all involved were handicapped by the absence of any statutory definition of what constituted prescribing **'in an irresponsible manner'**. It was, according to Mr Macfarlane, necessary to consider the detail of many individual prescribing transactions in order to establish 'beyond argument' a pattern of prescribing that was susceptible to only one conclusion, namely that it was irresponsible. If an adverse finding was made, the tribunal could recommend to the Home Secretary that a section 13 direction should be made. The Home Office had to give notice to the doctor of the intention to make a direction, setting out its proposed terms. The doctor could then make representations. If s/he did not, the direction could be made but, if s/he did, the Home Office had to refer these representations to a specially constituted advisory body. That body would advise the Home Secretary as to the exercise of his powers. On receipt of that advice, the Home Secretary could make a direction but he might or might not direct that the case be remitted to the tribunal or to a differently constituted tribunal. I understand why Mr Macfarlane described the process as 'tortuous'.
- 4.37 Mr Macfarlane said that only 14 section 13 orders were made between 1974 and 1993. He believes that about 25 to 30 cases went before a tribunal in the period between 1973, when section 13 came into force, and 1997, when the last case was concluded. The final nail in the section 13 coffin was a case that became very protracted owing to adjournments and concurrent police investigations. When eventually the case came before a tribunal, the tribunal made a limited recommendation that was contested by the doctor. The

proceedings became yet more protracted and eventually failed on the ground of excessive delay.

- 4.38 Since the early 1990s, the Home Office has not instituted any new applications under section 13. Not only was the procedure slow and ineffective, it was considered by the Home Office that the GMC was better placed to provide effective control over doctors who had prescribed irresponsibly. Mr Macfarlane is satisfied with the way in which the GMC has handled such cases.

### **The Power of the General Medical Council in Respect of a Practitioner Convicted of a Criminal Offence**

- 4.39 I shall consider the role of the GMC in the Fifth Report. For the present, it suffices to say that, where a doctor is convicted of offences concerning controlled drugs, or where there is evidence before the GMC that a doctor has prescribed controlled drugs irresponsibly or even unwisely, s/he is at least potentially liable to disciplinary action. This might result in the imposition of conditions or restrictions upon his/her continued practice or even, in a really serious case, in erasure from the medical register.
- 4.40 In the 1970s, when Shipman was referred to the GMC, its powers were very limited. It could erase or suspend a doctor from the medical register but could not impose any restriction or condition upon a doctor while allowing him/her to continue in practice. Since 1980, the GMC's powers have increased and the imposition of restrictions on the right to possess, prescribe, supply or administer controlled drugs, or a particular class of controlled drug, is not uncommon. In some cases, where a doctor is addicted to a drug, s/he will enter the GMC health procedures and will usually give undertakings as to the conditions under which s/he can continue to practise. These might well include a restriction on the right to prescribe or possess certain controlled drugs.

### **The Power of a Primary Care Organisation to Restrict a Doctor's Right to Prescribe Controlled Drugs**

- 4.41 Since 2001, a primary care organisation has had the power, under the provisions of sections 49F and 49G of the National Health Service Act 1977 (as amended), to remove a GP from its medical list or to impose conditions upon the doctor's continued inclusion on the medical list. The power to impose conditions on inclusion can be invoked only on the ground of prejudice to efficiency or fraud. At least in theory, these powers could be used to restrict the right of a doctor to prescribe controlled drugs following a relevant conviction or a finding of irresponsible prescribing, although the Inquiry is not aware of any case in which this has occurred.

### **Notification of Restrictions to Pharmacists**

- 4.42 Although the Home Office and the GMC have for a long time had the power to make orders restricting a doctor's right to prescribe controlled drugs, the Inquiry was told that the arrangements by which information about doctors who are made subject to such restrictions is disseminated to pharmacists are not satisfactory. The MDA 1971 provides

for publication of directions made under sections 12 and 13 in the London, Edinburgh and Belfast Gazettes, thereby recognising the need for proper notice to be given to the public. Not only have section 12 and 13 directions fallen out of use, publication in the Gazettes can no longer be regarded as a satisfactory means of bringing such matters to public notice. Until about ten years ago, the RPSGB used to publish periodically a cumulative list of doctors who were subject to section 12 and section 13 directions. This practice came to an end in unfortunate circumstances. The prohibition on one doctor whose name was on the list was removed after the draft had been sent to the printers. He was not pleased that his name still appeared when the list was published. Thereafter, the RPSGB, realising that it could not keep its list fully up to date, abandoned the publication and now publishes the telephone number of the Home Office so that pharmacists can check the current status of an individual prescriber. However, this is not satisfactory, as the telephone line is not manned continuously and pharmacists cannot access the information at night or at weekends.

- 4.43 The GMC does not circulate information to pharmacists about GMC restrictions upon a doctor's prescribing rights. If a pharmacist is in doubt about the status of a doctor who has signed a prescription, s/he can telephone the GMC and will be given the necessary information. However, this service is available only during working hours. Out of hours, the pharmacist can obtain some information from the GMC website or by means of an automated answering service, but these do not provide information about restrictions or conditions attached to a doctor's registration. For that information, it is necessary to speak to a GMC caseworker. It seems to me that these difficulties must be resolved.

## Conclusion

- 4.44 It is an almost inevitable corollary of the doctor's general freedom to prescribe controlled drugs that some will abuse that freedom. Some do so dishonestly and/or to feed their own habit; others may do so out of naïveté or weakness. The potential for significant harm is present whatever the motive or state of mind of the practitioner in question. Some cases have come to light where abuses have continued for many years before they were detected. Some abuses may never be detected. Better systems are needed to deter, prevent and detect such behaviour. In Chapter Fourteen, I shall consider ways by which these objectives might be achieved.