

## CHAPTER TWENTY TWO

### The General Medical Council's Health Procedures

#### Introduction

- 22.1 I have already explained how, in the 1960s and early 1970s, there was increasing concern about the ability of the existing regulatory system to deal adequately with the problem of doctors whose fitness to practise was impaired by ill health. The General Medical Council (GMC) had no power to deal with a doctor who was sick, unless s/he had been convicted of a criminal offence or was guilty of conduct that would amount to serious professional misconduct (SPM). Patients were not adequately protected against, for example, the chronic alcoholic who had not been convicted of a criminal offence and who, despite presenting an obvious risk to patients, had not been guilty of any misconduct which would have been considered by the GMC as falling within the definition of SPM.
- 22.2 The other problem was that, in cases where it was possible to use the GMC's disciplinary procedures to deal with a sick doctor, those procedures were punitive in nature and offered no mechanism for supervising a doctor, for supporting his/her attempts to rehabilitate or for placing restrictions on his/her practice during the rehabilitation process. Disciplinary hearings were conducted in public and afforded the doctor no medical confidentiality. Many people felt that this type of public hearing was an inappropriate – even inhumane – way of dealing with doctors who were suffering from a physical or mental illness. There was reluctance on the part of doctors to report colleagues who were known to be a risk to patients by reason of their illness. This reluctance was attributed, in part at least, to the inadequate means available for dealing with sick doctors.
- 22.3 In its Report, published in 1975, the Committee of Inquiry into the Regulation of the Medical Profession, chaired by Dr (later Sir) Alec Merrison (the Merrison Committee), recommended the establishment of the arrangements that were to become known as the GMC's 'health procedures'. The health procedures were introduced in the Medical Act 1978 (the 1978 Act) and came into operation in August 1980. The relevant provisions were later set out in the Medical Act 1983 (the 1983 Act). Over the period for which they were in force, they changed little. In this Chapter, I shall describe the procedures as they operated in December 2003, at the time of the relevant Inquiry hearings. Where there had been significant changes between the introduction of the procedures and December 2003, I shall describe those changes.

#### The Procedures in Outline

- 22.4 Health cases were handled by the GMC's Health Section. The health procedures included two distinct processes for dealing with doctors whose fitness to practise was, or might be, seriously impaired by reason of a physical or mental condition. The first process was commonly known as the 'voluntary' health procedures. The purpose of the voluntary health procedures was to protect the public from doctors whose fitness to practise was seriously impaired on health grounds and to help the doctors concerned to follow a programme of medical supervision and rehabilitation.

- 22.5 Under the voluntary health procedures, the GMC received medical evidence on the condition of the doctor under consideration. If the evidence revealed that the doctor was suffering from a serious impairment of health, as a result of which s/he was not fit to practise or was fit to practise only subject to medical supervision, limitations on his/her practice and/or other conditions, the doctor might then be invited to give undertakings based on any recommendations made by the medical examiners who had provided the medical evidence. The undertakings would relate to such matters as the acceptance of medical supervision, abstinence from alcohol or drugs (if appropriate) and any limitations on the doctor's professional practice that were deemed necessary. If the doctor agreed to the proposed undertakings, and complied with them, his/her case would be managed, supervised and reviewed regularly without the need for a formal hearing. If the doctor made a good recovery from the impairing condition, s/he would be released in due course from his/her undertakings and would be free to resume practice unsupervised and without restriction.
- 22.6 The second process occurred if a doctor decided to challenge the need for a medical examination or if s/he refused to accept medical supervision or any proposed limitations on his/her practice or if his/her health deteriorated or if s/he breached any undertakings previously given. In that event, his/her case would be referred to the Health Committee (HC), which had the power to suspend, or impose conditions on, the doctor's registration. The HC had no power to erase a doctor's registration but could, in certain circumstances, suspend a doctor's registration indefinitely.
- 22.7 At the time of the Merrison Report, it was thought that the largest category of case likely to be dealt with under the new health procedures was that arising from the abuse of alcohol and other drugs. That indeed proved to be correct and, for many years after their introduction, the number of cases referred to the health procedures that fell within this category was as high as 75% to 80%. Sometimes, the alcohol or drug abuse was combined with some other psychiatric condition. Dr Sheila Mann, a consultant psychiatrist, who was a member of the GMC from 1996 until July 2003 and was a health screener from 1996 until 2004, told the Inquiry that her impression was that about half the cases dealt with by the Health Section involved substance misuse in one way or another. Few cases involving purely physical impairment were referred to the GMC. A doctor suffering from such a condition is likely to have insight into the effect of his/her condition on his/her fitness to practise and to cease voluntarily to practise if s/he realises that this is appropriate. By contrast, a doctor suffering from a psychiatric illness, or abusing alcohol or drugs, may continue to practise when unfit to do so.
- 22.8 The Inquiry was interested in the health procedures for a number of reasons. First, the Inquiry was concerned to see how the GMC had handled cases involving the abuse of drugs or alcohol, especially those involving an element of misconduct, such as dishonesty. It was necessary for the Inquiry to consider how Shipman would have been dealt with if the health procedures had been in operation when his case was considered by the GMC. I wished to see what happened to such cases in practice. I wished to assess whether the health procedures have afforded sufficient protection for patients. I shall also look at some of the changes currently proposed for the treatment of cases with a health element under the new fitness to practise (FTP) procedures.

## **Evidence**

- 22.9 As well as receiving oral evidence from Dr Mann, the Inquiry heard from Mr Alan Howes, who was employed by the GMC between 1977 and 2002 and was Head of the Health Section from August 1985 until October 1986 and from 1997 until April 2001, and from Miss Jackie Smith, who has been employed by the GMC since 1998 and was a senior caseworker in the Health Section from January to September 1998 and Head of the Health Section from April 2002 until May 2003. Evidence about the health procedures was also given by Mr Finlay Scott, Chief Executive of the GMC, by Professor Sir Graeme Catto, the current President, and by Sir Donald Irvine, the immediate past President.
- 22.10 From 1981, the health screener and the HC were required by GMC Standing Orders to present Reports on their activities to the full Council at least once a year. For many years, these Annual Reports contained a great deal of information about the cases dealt with in the Health Section, about problems that had been encountered and about changes in practice and procedure. They provided very useful information about the development and operation of the health procedures during the 1980s and 1990s. More recently, the Annual Reports have been subsumed into the GMC's annual FTP statistics and are less informative.
- 22.11 Between 1998 and 1999, a team from the Department of Public Health Science, King's College London, and the Nuffield Institute for Health, University of Leeds (the King's College team), carried out an evaluation of the GMC's health procedures. The results of the evaluation were reported to the GMC in November 1999. I shall refer to this report as the 1999 Evaluation Report. The evaluation had been commissioned as part of an initiative by the then President, Sir Donald Irvine, to subject the GMC's FTP procedures to independent review. The evaluation involved a retrospective review of the GMC's management of health cases. The review was based on case notes relating to doctors who had been referred to the Health Section between 1980 and 1996. The King's College team carried out a quantitative study of the 771 cases for which case notes were available. The team also examined a random sample of reports submitted to the GMC by medical supervisors in the cases of 40 doctors who had been placed under medical supervision in the period 1989 to 1996 and whose cases had been concluded. The 1999 Evaluation Report provided a useful insight into the operation of the health procedures during the late 1990s and I shall refer to its contents in the course of this Chapter.
- 22.12 The first formal internal GMC guidance document dealing with the health procedures was entitled 'Health Screening: Guidance for Screeners and Health Section Staff'. It was produced in November 1999. I shall refer to it as 'the 1999 Guidance'. It was prepared at a time when the findings of the King's College team would have been known to the GMC. It no doubt reflected changes in practice introduced as a result of those findings. The 1999 Guidance (although out of date in some respects) was still in use in December 2003, when the Inquiry heard oral evidence about the operation of the health procedures.

## **Local Procedures for Dealing with Concerns about Doctors' Health**

- 22.13 If a doctor is ill and his/her employers or colleagues become aware that his/her illness is or may be affecting his/her fitness to practise, there will usually be some attempt to deal

with the matter locally. A hospital trust may use its own occupational health facilities to arrange a medical examination and may then place any necessary restrictions on the doctor's practice. For a general practitioner (GP) working as an independent contractor, however, the management of a health problem can be more difficult. Until recently, NHS primary care organisations (PCOs) had very limited powers to deal with sick doctors. Their recently acquired list management powers, however, mean that a primary care trust (PCT) is now able to remove or suspend a doctor from its list or to impose conditions on his/her continued inclusion on the list. This should make it possible for the PCT, in an appropriate case, to exert pressure on a doctor to accept medical advice and treatment and to restrict his/her practice as necessary.

- 22.14 Often, however, a GP's illness may not be known to his/her PCT. It may be evident only to the other doctors in his/her practice (if any) and/or to his/her treating doctor (if any). Not all doctors have an established relationship with a GP. Some treat themselves. In those circumstances, the problem may not have been recognised at all or, if it has been, there may be attempts to contain the problem privately, without the knowledge or intervention of the PCT. There are various support groups in existence that offer assistance to doctors with health problems, in particular those who are abusing alcohol and drugs.
- 22.15 In many cases, health problems can be resolved locally, without the involvement of the GMC. There are cases, however, where the doctor lacks insight into his/her condition and/or persists in practising when unfit to do so, thereby putting patients at risk. This is the type of case in which action is required by the GMC. In some cases, a PCT or NHS trust may act in concert with the GMC.

### Sources of Reports about a Doctor's Ill Health

- 22.16 The fact that a doctor is, or may be, suffering from a physical or mental condition serious enough to impair his/her fitness to practise may be brought to the attention of the GMC in one of a number of ways. It may be reported by a professional colleague of the doctor, by his/her employer or PCT or by a pharmacist, a patient or a member of the public. It might come from the National Clinical Assessment Authority (NCAA) as the result of its undertaking a performance assessment. On occasion, the report may come from the doctor him/herself or from a member of his/her family or his/her treating doctor. Often, the initial information will amount, not to a report, but to an enquiry about whether a report is appropriate. Sometimes, the information will be received by way of notification from the police that the doctor has been convicted of a criminal offence which might indicate the presence of an underlying health problem. The most common examples are drink driving convictions and convictions for drug-related offences. The fact that a doctor is, or may be, unwell may also come to light in the course of consideration of a doctor's case under the GMC's conduct or performance procedures.
- 22.17 The GMC becomes aware of only those cases which are referred to it. It has no means of knowing how many doctors with health problems are being managed locally and with what degree of success. The Inquiry was told that, in recent years, there had seemed to be a much higher level of awareness among members of the medical profession of their duty to report sick colleagues. As a consequence, there has been an increase in referrals to

the GMC, together with an increase in enquiries about whether or not a referral should be made.

- 22.18 Dr Mann said that the usual point of contact for the GMC was the doctor's partners (if the doctor was a GP) or his/her own GP or treating psychiatrist. There would sometimes be contact with the relevant local medical committee (LMC). It was less usual for a GP's PCT to get in touch with the GMC. However, she said that medical directors of PCTs had become more involved recently. Dr Mann had had experience of two PCTs using their powers of list management to impose conditions on the inclusion on their lists of doctors who were suffering from health problems. She thought that this was an encouraging development. However, she had some concerns about the capacity of very small, isolated PCTs to deal with doctors' health problems.

### **The Initial Process for Dealing with Reports about Health**

- 22.19 The health procedures were governed successively by the General Medical Council Health Committee (Procedure) Rules Order of Council 1980 (the 1980 Health Rules) and the General Medical Council Health Committee (Procedure) Rules Order of Council 1987 (the 1987 Health Rules).

#### **The Health Screeners**

- 22.20 Rule 5(2) of the 1987 Health Rules required the GMC to appoint either the President or some other member of the GMC to screen cases which raised a question about a doctor's health. If the President proposed to sit on the HC, or if for any other reason he did not wish to act as health screener, he was required to nominate another member of the GMC for appointment to the post. The 1987 Health Rules gave the President power to nominate a second member of the GMC to assist in the screening of health cases when, for any reason, the President or the health screener appointed in his stead was unable to act. In fact, an additional health screener had been appointed to assist the President since 1984.
- 22.21 In 1980, Professor Sir Denis Hill was appointed as screener, both for conduct and health cases. After Sir Denis' death in May 1982, Dr Philip Connell took over responsibility for screening health (but not conduct) cases. In November 1984, the then President, Sir John (later Lord) Walton, became screener for both conduct and health cases. Sir John was the last President to act as a screener. He was assisted, in relation to health cases, by Dr Connell. In November 1987, Professor Neil Kessel was appointed to give further assistance with the screening of health cases. In February 1989, after the end of Sir John's Presidency, Dr Connell became the health screener and Professor Kessel was appointed as additional health screener. In 1991, Dr Connell retired as health screener and was replaced by Professor Kessel. Dr Thomas Bewley was appointed as additional health screener. Professor Kessel retired in February 1995 and Dr Bewley took over, with Professor Andrew Sims as additional health screener. On Dr Bewley's retirement in July 1996, Professor Sims succeeded him, and Dr Mann, then a new member of the GMC, was appointed as additional health screener. In 1999, Professor Sims retired as health screener and Dr Mann succeeded him. Dr Michael Wilson, a GP, was also appointed a health screener at that time. Dr Mann and Dr Wilson remained in post until some time in

2004. In the past, most of the health screeners were consultant psychiatrists. This reflected the fact that most of the doctors dealt with in the health procedures were suffering from psychiatric problems.

- 22.22 As will now be apparent, there had been relatively few people involved in the screening of health cases from the inception of the health procedures. The system was that the knowledge and experience of each successive health screener was passed to his/her more junior colleague. When Dr Mann was first appointed, she had no formal training for the role. She read the GMC's literature about the health procedures and received advice from Professor Sims. At first, she assumed responsibility for the cases of doctors who were already in the voluntary health procedures and were under supervision, while Professor Sims dealt with new cases and with those to be referred to the HC. In that fashion, Dr Mann learned what the job of health screener entailed.
- 22.23 The role of the health screener was to direct action in new cases up to the point when the doctor was placed under medical supervision. The health screeners were then responsible for monitoring the doctor's progress under supervision. They also directed the preparations for hearings before the HC and for resumed hearings. All decisions that had any bearing on how a health case should be handled were, in the past, taken by a health screener, although the administrative arrangements were undertaken by GMC staff. Under the new FTP procedures, it seems likely that the staff of the Health Section will assume a far greater degree of responsibility for decision-making in health and potential health cases. It seems that the responsibility for many of the decisions on the handling of cases will pass from medically qualified GMC members to staff who, although possibly very experienced, will not be medically qualified. I shall refer to these changes further in Chapter 25.

## Referral of a Case to the Health Screeners

### *Referral by the Office Staff*

- 22.24 Rule 6(1) of the 1987 Health Rules provided that:

**'Where information in writing or a complaint in writing is received by the Registrar about any practitioner which raises a question whether the fitness to practise of the practitioner is seriously impaired by reason of his physical or mental condition, the Registrar shall submit the information to the President.'**

The functions of the Registrar were, in practice, undertaken by the GMC staff, and those of the President by the health screeners.

- 22.25 Where the information or complaint (I shall refer to both as 'information' for brevity) received by the GMC plainly raised a health issue, it was dealt with by the Health Section. It might be received direct by the Health Section or it might be passed to the Health Section from the Conduct Screening Section. From April 2003, a triage system was in operation, whereby a casework manager would consider any written information received and make an initial assessment. He or she would then make a recommendation as to the appropriate action to be taken and would delegate responsibility for the day-to-day



conduct of the case to a caseworker. The casework manager would consider whether the case might warrant the attention of the health screener with a view to referral to the Interim Orders Committee (IOC). He or she would also consider whether the case was a 'clear cut' health case or whether it had elements of conduct and/or performance, in which case it might have been appropriate for it to be referred in the first instance to a medical screener for conduct and performance cases. If neither of these courses of action appeared appropriate, the caseworker would prepare the case for submission to a health screener. The health screener would then decide whether the evidence raised a question of possible serious impairment of fitness to practise.

### ***Referral by a Medical Screener***

- 22.26 So far, I have dealt with cases which were immediately identified by the GMC staff as potential health cases. Some cases, however, came to the health screener via a medical screener. If, for example, a doctor had been convicted of a criminal offence, the General Medical Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988 as amended (the 1988 Professional Conduct Rules) required that the conviction (unless it was a minor motoring conviction) should be referred to a medical screener appointed to deal with conduct cases. Such a conviction might have a 'health element'. In a case where there had been no conviction but where there was an allegation of misconduct, it might not be recognised immediately that there was, or might be, a health element in the case. There might be a number of elements to the case, of which health was only one. In all those circumstances, members of the GMC staff would first refer the case to the medical screener, who would then decide how the case should be dealt with.
- 22.27 Rule 7 of the 1988 Professional Conduct Rules gave the medical screener two options for dealing with a case in which it appeared to him/her that the fitness to practise of a doctor might be seriously impaired by reason of his/her physical or mental condition. The first option was to direct the staff to inform the doctor of the medical screener's view about the possible impairment of fitness to practise through ill health and to invite the doctor to provide medical evidence for consideration by the Preliminary Proceedings Committee (PPC). Dr Mann said that, in practice, such a case would be referred to the health screener, who would arrange for the doctor to be examined by medical examiners from the GMC's list. (I shall refer to the role and function of such medical examiners later in this Chapter.) It would then be open to the PPC, having considered the medical evidence and received the advice of the health screener, to refer the case to the Professional Conduct Committee (PCC) for a disciplinary hearing, or to the health screener for action under the voluntary health procedures or to the HC.
- 22.28 The second option open to the medical screener was to remit the case to the health screener for action under the 1987 Health Rules as an alternative to referring the case to the PPC. Dr Mann said that this would be done when it appeared to the medical screener preferable that action should be taken under the health, rather than the conduct, procedures. According to the 1999 Guidance, a medical screener could refer a case into the voluntary health procedures without the concurrence of a lay screener, provided that no question of SPM arose. If a question of SPM arose but the medical screener was of the

view that it was nevertheless in the public interest that the case should be transferred into the health procedures, this could be done, but only with the concurrence of a lay screener. There was no requirement for the lay screener to agree in a conviction case.

- 22.29 Dr Mann said that only 'a very few' cases reached the health screener by way of the medical screener. She said that, as well as receiving formal referrals, she would sometimes receive informal requests for advice from medical screeners as to whether the doctor's fitness to practise might be seriously impaired because of health and whether it would be appropriate to obtain a medical report before a case was referred to the PPC.

### ***Referral by the Preliminary Proceedings Committee***

- 22.30 As I have explained in Chapter 20, it was common for a health screener to be present at PPC meetings at which conduct cases with a potential health element were considered. Usually, the health screener would advise whether a medical examination of the doctor appeared appropriate. If s/he advised that it did, and if the PPC decided to adopt that course, the health screener would arrange for the doctor to be invited to submit to medical examination and the PPC would adjourn consideration of the case for that purpose. Provided that the doctor agreed, the examination would take place and, if appropriate, the doctor would be invited to give voluntary undertakings. If the doctor agreed to do so, the health screener would report back to the PPC, which would then close the case under the conduct procedures. Referral to the voluntary health procedures formally occurred at the point when the doctor agreed the undertakings. If a doctor failed to co-operate with the examination, or refused to agree undertakings, the case would return to the PPC which would then consider what further action was necessary. The PPC might then refer the case to the PCC or to the HC.

### ***Convictions for Drink Driving Offences***

- 22.31 Until 1995, the PPC did not routinely request that doctors convicted of drink driving offences should be medically examined with a view to ascertaining whether their convictions resulted from addiction to alcohol. Instead, it would request the health screener to arrange a medical examination only in cases where the doctor's alcohol level had been at least two and a half times in excess of the legal limit or where s/he had a previous drink driving conviction. By 1995, however, there was concern that there might be cases which did not fulfil either of these criteria but where the doctor might nevertheless be suffering from a health problem which would benefit from early intervention. Accordingly, from that time, the PPC adjourned the cases of all doctors who had been convicted of an offence of drink driving so that they could be medically examined. The results of those examinations revealed that some doctors who had been convicted of only one offence of drink driving and whose alcohol levels had been less than two and a half times the legal limit were nevertheless suffering from a seriously impairing condition.
- 22.32 In 1998, there was a change of procedure whereby the health screener would arrange for a medical examination before the case was considered by the PPC. It seems likely that, if it was clear from the report that the doctor had a health problem, the health screener would invite the doctor to give voluntary undertakings. If the position was not clear, or if the doctor



was not willing to give undertakings, the case would be referred back to the PPC for decision.

- 22.33 Dr Mann said that the majority of doctors convicted of offences of drink driving were found to be fit to practise without restriction. However, about one third were found to have a health problem. Some of these were placed under supervision in the voluntary health procedures.

### **The Power of the Health Screener to Investigate**

- 22.34 Under rule 6(3) of the 1987 Health Rules, once a case had been referred to him/her, the health screener had power to cause such inquiries to be made as s/he might think fit. Dr Mann said that she would sometimes suggest people whom the staff might contact to obtain information. She might even suggest writing to the doctor him/herself at that stage.

### **Consideration of a Case by the Health Screener**

#### ***The Sufficiency of the Evidence***

- 22.35 Dr Mann told the Inquiry that the first question the health screener had to consider was whether there was sufficient evidence that the doctor's fitness to practise might be seriously impaired. She emphasised that there must be sufficient firsthand evidence.
- 22.36 Sometimes, the person (usually a doctor) who had originally reported the concern to the GMC was unwilling to supply evidence on which GMC action could be based. The relevant information had to be put in writing. In addition, until November 2002, in a case where information about a doctor's health was received from a private individual, that information would not be submitted to a health screener unless and until a statutory declaration (i.e. a statement confirming the truth of the information, sworn in front of a solicitor or a member of certain other limited classes of person) had been provided. The rule applied even when the information came from a colleague of the doctor or from his/her treating doctor. In November 2002, as I have previously explained, the requirement for a statutory declaration was removed. Dr Mann said that this requirement had caused problems and was 'quite troublesome' for some members of the public. She said that she was 'very glad' that it had been removed.
- 22.37 Throughout the 1980s and early 1990s, considerable concern was expressed in the Annual Reports of the health screener about the fact that some doctors were reluctant to co-operate by providing the information required by the GMC in the correct form. It seems likely that part of the problem was the requirement for a statutory declaration. The unwillingness of the GMC to carry out its own investigations and to gather evidence itself was no doubt also a factor. However, there seems also to have been a feeling on the part of some doctors that, once they had expressed their concerns to the GMC, they had 'done their bit' and they had no obligation to do more. In the 1991 Annual Report of the health screener, this attitude was condemned as '**a failure of duty both to patients and to the sick doctor**'. Over the years, a significant number of cases were closed because of insufficient evidence.

- 22.38 The 1999 Evaluation Report revealed that, between 1981 and 1996, 10% of the 771 cases examined by the King's College team had been closed because the GMC had considered that it had insufficient evidence to warrant instigating the health procedures. Examples were cases where there was no firsthand (as opposed to hearsay) evidence that patient safety was being compromised or where firsthand information was available, but it was not in the correct form. The Report showed that a significantly lower percentage of cases was closed for this reason during the period from 1989 to 1996 than in the earlier period from 1980 to 1988; 14% were closed during the period from 1980 to 1988, compared with 7% in the later period.
- 22.39 The King's College team noted that, overall, one third of cases that had been closed owing to insufficient evidence subsequently returned to the GMC with a second health-related referral. The figure for such cases from the period 1989 to 1996 was almost 40%.
- 22.40 The 1999 Evaluation Report recommended that, once contact had been made by a person concerned about a doctor's health, the GMC should be more proactive in following up the information (regularly if necessary) until it was sure that the doctor was not a risk to patients. The Report suggested that caseworkers might be sent out to talk to potential referrers about their concerns. It also recommended that more assistance and advice should be made available to potential referrers.
- 22.41 From the contents of the 1999 Guidance, it seems that the GMC took some steps to implement those recommendations. It appears that advice was given to referrers about making a statutory declaration. Sometimes, the GMC was able to arrange for the colleagues of a doctor who wished to give information about the doctor's health to the GMC to avoid the need for a statutory declaration by channelling their reports through a hospital authority, a PCO or a LMC. However, informants did not always want to do this and the relevant organisations were sometimes unwilling to assist. In certain cases, referral through the GMC's solicitors could be arranged or financial assistance made available to a private individual, to enable him/her to make a statutory declaration. A system of following up enquiries about referrals was developed.
- 22.42 The annual FTP statistics reveal that, from 1996, the percentage of cases closed on the grounds of insufficient evidence fluctuated widely. For example, in 1999, the statistics show that only one out of the 157 health cases referred was closed for this reason. In 2001, however, the figure was 30 out of 181 cases. The figures for 2002 and 2003 were 13 (out of 202 cases) and six (out of 143 cases) respectively. It is not known how many of these cases were later (or will in the future be) followed by a further health-related referral.
- 22.43 In Chapters 18, 19, 20 and 21, relating to the conduct procedures, I discussed the consequences of the GMC's unwillingness to gather evidence or to investigate complaints proactively until a very late stage in the disciplinary process. I expressed the view that this unwillingness probably resulted in the loss of some cases to the FTP procedures. It would appear that, at times and to some extent, a similar problem affected the health procedures. I had the impression from the evidence of Dr Mann that, once a case had been referred to her, she would instigate investigation. But it might well be that, on occasion, cases were closed for lack of firsthand evidence before they reached the health screener. It appears that the requirement for a statutory declaration was probably the

cause of the problem in some cases. The stated justification for requiring a statutory declaration in the conduct procedures was to protect doctors from being harassed by unfounded or malicious complaints. I find it difficult to imagine why such measures should have been thought necessary within the health procedures, which are designed to protect the public and to assist the doctor without punishing him/her. Yet the requirement was retained until 2002.

### ***The Seriousness of the Impairment***

22.44 Another consideration for the screener was whether the information received raised a question of 'serious' impairment, rather than some mild form of illness. Some of the cases considered by the Inquiry showed that quite difficult issues could arise when the health screeners had to decide whether to 'accept' a case and direct a medical examination, or to close it. It does not appear that there has ever been any guidance on these issues. In the past, this probably did not matter, as such decisions were taken by one of two health screeners, who were very experienced. However, for the future, it seems to me that some guidance and criteria will be needed.

### ***The Adequacy of Any Local Action Being Taken***

22.45 Rule 6(4) of the 1987 Health Rules stated that, unless it appeared to the health screener that the matter '**need not proceed further**', s/he should set in motion the initial steps in the health procedures. Dr Mann said that, when considering whether there was a '**need**' for a case to proceed further, she was required to look at whether the problem had been, or could be, remedied by local action. Evidence of any actual or potential risk to patients would be a relevant consideration. If a doctor's problems were being dealt with locally, she would consider whether the doctor was showing insight, whether s/he was accepting advice about treatment and about his/her fitness to practise and whether s/he was taking appropriate treatment and medication. Dr Mann said that, with a GP, the size of his/her practice was relevant. In a group practice, there was more chance of a problem being spotted and of arrangements being made if the doctor became unfit to practise. Dr Mann said that, in an ideal world, she would like to think that local measures would normally be sufficient for a doctor in stable employment. There were, however, problems with doctors who moved around. There was often no place where their problems could be consistently managed. The GMC would usually invite such a doctor to be medically examined. The GMC was in a better position than local organisations to deal with peripatetic doctors since it could organise supervision countrywide and could refer a doctor to the HC if s/he failed to keep in touch with his/her nominated supervisor.

22.46 The 1999 Evaluation Report revealed that, in the period between 1980 and 1996, 7% of cases referred to the health screener had been closed on the grounds that they were being adequately controlled by local measures. Twenty eight per cent of those cases had resulted in a subsequent health-related referral. There were far fewer second referrals (15% compared with 46%) among cases closed between 1989 and 1996 than among those closed between 1980 and 1988. However, the Report pointed out that there had, by 1999, been less time for a recurrence in cases closed more recently.

- 22.47 The 1999 Evaluation Report recommended that clear criteria and guidelines should be established to assist health screeners in assessing when a case was being controlled adequately by local measures and when GMC intervention was required. It was suggested that, if a case was to continue to be managed locally, a system of periodic monitoring by the GMC was necessary. The 1999 Evaluation Report was the second occasion when an external body had called upon the GMC to establish clear criteria and guidelines for the assistance of decision-makers. I have already mentioned in the Chapters dealing with the conduct procedures that Professor Isobel Allen called for the establishment of clear standards, criteria and thresholds, to be applied by decision-makers when dealing with conduct cases. The 1999 Guidance produced by the GMC included some sample cases to illustrate the type of problem that could be managed locally and the kind of case that should be referred to the GMC. Although the GMC maintained that the 1999 Guidance set out criteria, it does not seem to me that it did. The sample cases were no doubt helpful but they did not establish criteria for the health screeners to apply.
- 22.48 Following receipt of the 1999 Evaluation Report, the Health Section developed a system whereby it would follow up the case of a doctor who was being dealt with locally to ascertain that all was well. The follow-up might take place after two, four, or six months, depending on the seriousness of the case and how robust the local procedures were thought to be. Sometimes, there would be regular follow-up over a long period.

#### ***Referral to or Consultation with a Medical Screener***

- 22.49 Dr Mann said that, if there was a conduct or performance aspect to a case which was referred directly to her as a health screener, she would refer the case to a medical screener. She might at the same time set the health procedures in motion by asking the staff to write to the doctor. In some cases, there was a dialogue (either face to face or on paper) between the medical and health screeners as to how a case should best be dealt with.

#### ***Interim Action***

- 22.50 After the IOC was established in August 2000, it was also open to the health screener, in an appropriate case, to refer a doctor to that Committee. Before that time, the health screener had power to refer a case to the PPC for consideration of the making of an interim order, but only where a decision had already been made to refer the case to the HC and where the health screener thought that it might be desirable for an interim order to be made pending the HC's consideration of the case. If the case was referred to the PPC for the purpose of an interim order, it was not open to the PPC to refer the doctor to the PCC; it could only proceed to the HC.
- 22.51 Dr Mann said that she had been 'extremely grateful' for the establishment of the IOC. Before it came into being, there was sometimes nothing she could do about doctors who were seriously ill, usually with psychotic disorders, but still in practice. Presumably, these were cases in which it was not appropriate for the doctor to be referred to the HC because s/he had not yet declined to co-operate with the voluntary procedures. I have observed,

in connection with the conduct procedures, that it is surprising that, until 2000, the GMC took no steps to obtain comprehensive powers to make interim orders for the protection of the public. There must have been many cases in which the power would and should have been used. Yet it does not appear that the need for it was recognised until it was found that the GMC could do nothing to stop Shipman from practising although he was under investigation for murdering patients. From Dr Mann's evidence, it appears that there was also a need for a flexible power to make interim orders in health cases. One would have thought that the GMC would have recognised this *lacuna* in its powers before it did.

### **The Invitation to Undergo Medical Examination**

22.52 If the health screener decided that the case should proceed, s/he was then required to direct the GMC staff to write to the doctor, notifying him/her that information had been received by the GMC which appeared to raise a question whether his/her fitness to practise was seriously impaired and indicating the nature of the alleged impairing condition. Dr Mann said that, sometimes, it was impossible to identify the impairing condition at that stage and it was necessary to use some general term of description such as 'substance misuse'. The doctor would be invited to submit to examination by at least two medical examiners, to be chosen by the health screener, and to agree that such examiners should provide reports on his/her fitness to practise. The 1987 Health Rules allowed the doctor 14 days in which to respond to the invitation.

### **Medical Examiners Chosen by the General Medical Council**

22.53 Medical examiners were chosen by the health screener from lists of doctors nominated for the purpose by professional organisations, including the medical Royal Colleges (primarily the Royal College of Psychiatrists) and various committees of the British Medical Association. They were usually of considerable seniority. The most common specialty from which medical examiners were drawn was psychiatry. Dr Mann said that the health screeners tried very hard to identify examiners who were appropriate for the particular condition suffered by the doctor. Cases of alcohol and drug addiction were dealt with by consultant psychiatrists, usually specialists in substance abuse. Examinations would take place in the doctor's locality wherever possible.

### **Medical Examiners Nominated by the Doctor**

22.54 Under the original procedure set out in rule 6(3)(c) of the 1980 Health Rules, the doctor was also informed that it was open to him/her to nominate other medical practitioners to examine him/her and to report to the health screener on his/her fitness to practise. These reports would be prepared at the GMC's expense. In November 2002, the rule was changed to remove the right of a doctor to nominate other medical practitioners to examine him/her. Dr Mann said that the right had not been exercised to any great extent. She was not sure why it had been removed. She said that, in fact, it was still open to a doctor to nominate a medical examiner if s/he wished to do so. However, the GMC would not pay for the report.

### ***Other Information Submitted by the Doctor***

22.55 In addition, at the same time as s/he was invited to submit to medical examination, the doctor was invited to provide any submissions or to provide other evidence which s/he might wish to offer as to his/her fitness to practise. From November 2002, the Rules specifically provided that such '**other evidence**' might include medical evidence. Even before that time, however, it was not unusual for the doctor to submit medical evidence to the GMC at this point in the process or, if the doctor was aware at the time of his/her referral to the GMC that s/he had been referred, even earlier. The medical evidence submitted by the doctor might consist, in a conviction case, of reports that had been prepared for the previous court hearing. Alternatively, it might consist of a report from a treating psychiatrist, or from the doctor's GP. Dr Mann estimated that doctors produced medical evidence of their own in about a quarter of cases. She said that such evidence was taken into account by the health screeners. However, she told the Inquiry that, unless there was clear evidence that the doctor's fitness to practise was not seriously impaired and that patients were not at risk, the doctor would be invited to undergo examination by examiners who had been chosen by the GMC, even if s/he had produced medical evidence of his/her own. The examiners chosen by the GMC would be familiar with the GMC's requirements for the content of an examination report and would also provide objective assessments. She said that there had been occasions when a doctor had produced a report from a medical practitioner who was on the GMC's list of medical examiners and where the GMC had accepted and acted on that evidence. In general, however, the GMC would want to obtain two independent reports.

### ***Reports of Previous Medical Examinations***

- 22.56 The information originally received by the GMC, notifying it of concerns about a doctor's health, might include reports written by medical practitioners who had recently examined the doctor. The doctor might, for example, have undergone a medical examination arranged by his/her employers, who might have forwarded the report to the GMC.
- 22.57 Rule 6(4)(b)(ii) of the 1987 Health Rules provided that, in those circumstances, and if it appeared to the health screener that those reports afforded sufficient medical evidence that the doctor's fitness to practise might be seriously impaired by reason of a physical or mental condition, the health screener should direct the staff to inform the doctor of that fact. In that event, the invitation to the doctor to submit to a medical examination would be dispensed with. Until November 2002, it was still open to the doctor, in these circumstances, to nominate his/her chosen practitioners to examine him/her and to prepare reports at the GMC's expense, in addition to those submitted by the person or body who made the original referral.

### ***Disclosure of Information to the Doctor***

22.58 Rule 6(5) of the 1987 Health Rules provided that the health screener might direct the staff to send to the doctor, at the same time as notification that information about his/her health had been received, a summary of that information, together with copies of any reports from medical practitioners who had recently examined the doctor. This was routinely done. If

the health screener considered that there was any material in the reports which was not relevant to the doctor's current fitness to practise, or which it would not be in the doctor's best interests to see, the Rules made it possible for that material to be excluded from the documents sent to the doctor. However, any material excluded in that way could not subsequently be put before the PPC or the HC.

- 22.59 Dr Mann said that she could not remember an occasion when evidence had been excluded under this provision. She thought that there was more openness now as regards the disclosure to patients of information about their condition than there had been when the Rules were originally drafted.

### ***Warning the Doctor about the Consequences of a Refusal to Submit to Examination***

- 22.60 Rule 6(4)(e) of the 1987 Health Rules introduced a new requirement, namely that the doctor should be informed that, if s/he refused to be examined, or if, having agreed, s/he subsequently failed to submit to medical examination, or if s/he did not reply within 28 days to the GMC's communication, his/her case might be referred to the HC. This provision was presumably added with a view to providing additional encouragement to the doctor to give a positive and timely response to the invitation to submit to medical examination.

### **Disclosure to the Doctor's Employer or Primary Care Organisation**

- 22.61 By section 35(B) of the 1983 Act, which was inserted in August 2000, the GMC was required to disclose to any person in the UK by whom a doctor was employed to provide medical services, or with whom s/he had an arrangement to do so, the fact that the doctor was undergoing an investigation to determine whether his/her fitness to practise was seriously impaired by reason of his/her physical or mental condition. The disclosure had to be made as soon as was reasonably practicable after the doctor had been invited to agree to submit to medical examination or had been notified that medical reports already received by the GMC appeared to provide evidence that his/her fitness to practise might be seriously impaired. Disclosure would therefore be made to a GP's PCO. Before the duty to disclosure existed, it was possible for a doctor's employer or PCO (particularly the latter) not to be aware that a doctor was being dealt with in the voluntary health procedures. It is not clear to me whether disclosure should also have been made, as a matter of course, to other members of his/her practice. In fact, it seems to me that a GP's partners might well be persons with whom the doctor has an arrangement to provide medical services. I would have thought a general practice partnership agreement would come within that rather wide provision. In any event, the GMC would have had the power to make disclosure to members of the practice under section 35(B)(2) on public interest grounds. However, it appears that the GMC does not, as a rule, inform the partners that the GP is undergoing investigation. In practice, a partner or employer or PCO will often have referred the case to the GMC and so will be fully aware of the situation. However, they may be unaware of a referral by a member of the public, a colleague of the doctor, or a treating medical practitioner.
- 22.62 Dr Mann observed that the duty to disclose had been a considerable improvement as far as employers and PCOs were concerned. However, she said that she would prefer the



contact to be at local level (i.e. the doctor informing his/her employers or PCO about a health problem), rather than the GMC 'sending down information from on high'. She believed that 'the best way of ensuring that doctors remain fit to practise is that there is understanding of their needs and that they in turn are honest with their employer'.

- 22.63 I agree that open discussion of the matter between a doctor and his/her employer or PCO is greatly preferable to the employer or PCO being informed by a third party of the doctor's problems. Nevertheless, in some cases, the nature of the doctor's illness – together with concerns about its possible effects on his/her career – will inevitably mean that this will not happen. Disclosure by the GMC does at least mean that employers and PCOs can be aware of the problem at an early stage in the GMC's proceedings and can take whatever steps they deem necessary to support the doctor and to safeguard patients. It seems to me highly desirable also that other members of a GP's practice should be fully aware of any report of health problems made to the GMC.

### **The Arrangements for Medical Examination**

- 22.64 Rule 7 of the 1987 Health Rules provided that, if the doctor agreed to submit to examination by medical examiners nominated by the GMC, the Registrar (in practice, the GMC staff) would make arrangements for the examinations to take place. The medical examiners were to be sent the information received by the GMC and were to be asked to report, first, on the fitness of the doctor to engage in practice, either generally or on a limited basis, and, second, on their recommendations, if any, as to the management of his/her case. While the GMC would be responsible for arranging the medical examination in principle, practical details such as time and place had to be agreed between the doctor and the medical examiner. Problems could occur at this stage if the doctor failed to co-operate or to attend for appointments.
- 22.65 When preparing their reports, medical examiners were asked to contact the doctor's GP and any other treating doctor. They were encouraged to interview an additional informant, such as the doctor's spouse, a family member or a friend. This was not always possible; it might be that no one was available, or that the doctor would not consent to such an interview. Dr Mann said that the examination followed very much the pattern of an examination by a doctor of a new patient. However, the examiner's attention was also directed to matters such as the risk to patients, the doctor's fitness to practise and whether there was a serious impairment present. In a case involving the abuse of drugs, one of the medical examiners would carry out objective testing for the presence of drugs. The medical examiners would liaise between themselves to arrange how and by whom this should be done. The examiners did not normally see each other's reports.

### **Acting on the Medical Evidence**

#### ***The Content of the Medical Reports***

- 22.66 Once completed, the reports of the medical examinations were forwarded to the GMC for consideration. In addition to the elements usually contained within a medical report, the medical examiners would set out their recommendations about such matters as the need

for medical supervision, treatment and support. They would also, in an appropriate case, recommend what limitations should be imposed on the doctor's practice. They might recommend that the doctor should cease practice for a period.

- 22.67 The 1999 Evaluation Report emphasised the need for GMC examiners, when reaching their conclusions about fitness to practise and when making their recommendations, to balance the interests of the individual doctor and the wider patient population. The impression of the King's College team was that, on occasion, the perceived effects for the doctor might have been given '**undue weight**' by examiners. If this impression was correct, it is worrying, because the primary objective of the health procedures must be to protect patients.

### ***Disclosure of the Medical Reports to the Doctor***

- 22.68 Rule 8 of the 1987 Health Rules required the health screener, when the reports of any medical examinations were available, to arrange for copies to be sent to the doctor concerned. It was open to the health screener to delete from the reports of the medical examiners chosen by the GMC any material which s/he considered irrelevant or not in the doctor's best interest to see, subject to the fact that the material would then be excluded from subsequent consideration by the PPC, the HC or the IOC. However, during the period up to November 2002, when it was still open to the doctor him/herself to nominate medical practitioners to examine him/her and to report, the health screener could not delete any material from reports prepared by the examiners nominated by the doctor. Dr Mann said that, when material was deleted from the reports of medical examinations, the deletions would 'nearly always' relate to information provided to the medical examiners by third parties.

### ***No Serious Impairment of Health***

- 22.69 The medical examiners might agree that there was no serious impairment of the doctor's fitness to practise. This happened most commonly in cases where the medical examination had taken place following a doctor's conviction for a drink driving offence. It was not a common outcome in other types of case. When it happened, the health screener could take no further action and the case would usually be concluded. The exception was where the case had been referred for a medical examination from the conduct or performance procedures, when those procedures might resume.

## **The Voluntary Health Procedures**

### **Where the Medical Examiners Agreed that a Doctor Was Unfit to Practise or Unfit to Practise without Conditions**

- 22.70 The most common outcome of a medical examination was a finding that the doctor was fit to practise, subject to restrictions and conditions recommended by the medical examiners. Rule 8 of the 1987 Health Rules provided that, in a case where the medical examiners were unanimous in their view that the doctor was not fit to practise except on a limited basis or under medical supervision or both, the health screener should direct the

staff to seek the doctor's agreement to undertake voluntarily to comply with the recommendations contained in the reports as to the management of his/her case, including any limitations on his/her practice which might have been recommended. If the doctor was not considered by the medical examiners to be fit to practise, even on a limited basis, s/he would be asked to undertake to refrain from practice altogether.

- 22.71 Undertakings were of two kinds. The first kind comprised those that related to the medical treatment of the doctor's condition. Undertakings of this kind might be to abstain from alcohol or to comply with tests for the presence of alcohol and other drugs. The second kind related to the doctor's practice. These might include an undertaking not to perform any work as a locum or deputy or for a deputising service, or even an undertaking to refrain from practice altogether. In formulating the undertakings, the health screener would confine him/herself broadly to the contents of the examiners' reports, but might add other undertakings as appropriate. The terms of the undertakings were usually derived from a list of 'standard undertakings' which had been developed by the GMC over time. They would be adapted as necessary to suit individual circumstances.
- 22.72 The 1980 Health Rules made no formal provision for the medical supervision of a doctor within the voluntary health procedures. From the first, however, medical supervision was one of the most important components of the voluntary health procedures and doctors were required to undertake to accept and co-operate with medical supervision. This remained a standard undertaking which was compulsory. Other compulsory undertakings were agreement (in a case of substance misuse) to undergo testing of samples of breath, blood, urine or hair for the presence of alcohol or drugs, and to allow the exchange of information between the medical supervisor and someone in the doctor's workplace. If the doctor was not prepared to give one of the compulsory undertakings, his/her case would be referred to the HC. Dr Mann said that, if a doctor was working, it was normal to include a requirement that s/he should seek the prior approval of his/her supervisor before taking up a new post and should cease working immediately if so advised. She said that it was also important to ensure that the doctor was registered with a GP and that the medical supervisor was in a position to exchange information with that GP. Dr Mann said that there was sometimes some 'negotiation' over certain undertakings. However, she observed that the overriding concern was the protection of the public. Dr Mann said that the health screeners would often require an undertaking that GPs with health problems did not work in single-handed practice, but instead worked in a group or partnership arrangement.
- 22.73 From about 1997, it was compulsory for a doctor entering the voluntary health procedures to agree that undertakings relating to his/her practice could be disclosed to his/her employers and to anyone seeking information about his/her registration status. If s/he did not agree to such disclosure, his/her case would be referred to the HC. There was no requirement for undertakings relating to the doctor's medical treatment to be disclosed and they were regarded as confidential. The purpose of the requirement for disclosure was to place doctors in the voluntary health procedures on a par with those who had been referred to the HC, and to ensure that members of the public and employers had access to the same information about both. All doctors who were already in the voluntary health procedures were asked to agree to disclosure. The disclosure, to employers and to members of the public making enquiry, of undertakings relating to the doctor's practice is

useful but it does not provide a complete picture. The letter of disclosure, examples of which the Inquiry has seen, might well leave an employer puzzled as to the nature of the doctor's problem. However, as Dr Mann observed, it would be open to an employer to contact the person instructed to act as the doctor's supervisor, although s/he would be able to disclose more information only with the doctor's consent. It is, perhaps, more likely that an employer would speak directly to the doctor and insist that, if the doctor was to remain at work, full details of the problem must be disclosed.

22.74 Mr Howes said that he believed that, towards the end of his time in the Health Section in 2001, the GMC would have kept a doctor's employers or PCO informed about progress and about undertakings relevant to practice. However, the GMC would not have notified a GP's professional partners. He believed that the GMC would have relied on the medical supervisor to keep the doctor's partners aware of what was happening. He pointed out that the partners might have been the original informants, in which case they would be well aware of the circumstances. Mr Howes observed, 'By the time I left this work, our policy was to make sure that everybody who needed to know, knew – everyone who had a proper interest in knowing, knew.'

22.75 The 1987 Health Rules made it possible for the first time to invite a doctor to give an undertaking in circumstances where s/he had recovered from a recurring or episodic physical or mental condition which was in remission at the time of the examination, but which might, in the future, be expected adversely to affect his/her fitness to practise.

### **Where the Medical Examiners Disagreed**

22.76 In a case where the medical examiners did not report unanimously, the health screener had to decide what arrangements for the management of the doctor's case (including limitations on his/her practice) were appropriate **'in the light of the balance of opinion in the reports'**. The doctor would then be invited to undertake to comply with those arrangements.

22.77 Dr Mann said that, on occasion, one medical examiner would say that a doctor was fit to practise and the other would say that s/he was not fit to practise. In those circumstances, she would 'err on the side of caution' and draft undertakings based on the report of the medical examiner who had expressed the view that the doctor was unfit to practise, hoping that the doctor would agree to them. If one medical practitioner recommended that the terms of the undertakings should be stricter than did the other, she would usually invite the doctor to agree to the stricter undertakings, with the possibility of a relaxation of their terms in time, if the doctor progressed satisfactorily.

### **The Doctor's Response**

#### ***Where the Doctor Gave Undertakings***

22.78 If the doctor undertook to comply with the recommendations contained in the medical reports (or, where the medical reports were not unanimous, with those proposed by the health screener), the health screener might then, if satisfied that the undertakings were being observed, postpone further action on the case. The doctor was then in the voluntary

health procedures. Once the doctor was within the voluntary health procedures, his/her case could not be referred back into the conduct or performance procedures.

### ***Where the Doctor Declined to Co-operate***

- 22.79 If the doctor did not agree to give undertakings, or failed to respond within the specified period, or if s/he refused or failed to comply with a medical examination by the medical examiners appointed by the GMC, the health screener might, if s/he thought fit, refer the case to the HC. In practice, few doctors declined to co-operate at this stage.
- 22.80 Until November 2002, there was an additional element to the process. Before making a referral to the HC, the health screener was required to consult with at least two other members of the GMC. The GMC maintained a panel of six members ('the panel of six') who were appointed for this purpose. Members of the panel (who could not also be members of the HC) were appointed by the President with the approval of the Council. Their views were not necessarily determinative of the health screener's decision whether to refer a case to the HC, but the health screener was required to take account of those views in reaching his/her decision. If, however, the health screener considered that, in the public interest, it was urgent that the case should be referred to the HC, s/he had the power to give a provisional direction to that effect before consulting the other members.
- 22.81 Dr Mann said that consultation with the panel of six caused something of a delay. It did enable a health screener to get another opinion on the case, which was helpful. On the whole, however, it did not add anything to the procedures. The original purpose of the requirement to consult other members of the GMC had been, she said, to protect doctors against screeners who, the profession feared, would want to refer every case to the HC. In the event, the fears of the profession had not been justified. The panel of six was abolished in November 2002.

### ***Where the Doctor Was Unfit to Give Undertakings***

- 22.82 In some cases, the medical reports might reveal that the doctor was suffering from a condition (usually a psychiatric condition) which meant that s/he was not fit to give undertakings or could not be relied upon to comply with undertakings, even if given. In such a case, it was open to the health screener to refer the case to the HC without first seeking undertakings from the doctor.

### ***Delays in Bringing Doctors under Supervision***

- 22.83 The 1999 Evaluation Report expressed concern about the time taken from a report about a doctor's health being received by the Health Section to the point when the doctor was placed under supervision. During the period from 1989 until 1996, it took a mean time of almost 50 weeks. Forty per cent of the doctors who were subsequently found to be unfit to practise unsupervised and unrestricted were known to be working at the time of referral. Some of those doctors were receiving treatment and might have been voluntarily restricting their practice, but many might not. The delay in bringing those doctors under supervision represented an obvious risk to patient safety. Until August 2000, however,

when the IOC was established, the health screener had no power to refer a case to the PPC for the making of an interim order unless and until the decision had been taken to refer a doctor to the HC. That could not be done unless there was evidence of failure to co-operate or non-compliance by the doctor.

- 22.84 The 1999 Evaluation Report identified a number of factors that had contributed to the delays. In the initial stages, there was sometimes a need to await the outcome of police investigations or court proceedings. Another factor was the time taken by some people who reported doctors to the GMC to provide the information required of them. A third factor was the time taken by doctors to respond to communications from the GMC.
- 22.85 The King's College team observed that, in some of the 40 sample cases which it examined in depth, the GMC had taken positive action to obtain information, sometimes by instructing its solicitors to investigate. However, in other cases, the GMC had waited for a complainant to make contact, rather than actively following up the complaint. Even when the GMC took positive action, this took a long time. The time permitted by the 1987 Health Rules for doctors to agree to examination (14 days) and to respond to the reports of the medical examiners (28 days) also slowed down the process. This was a matter which had been mentioned in the Annual Reports of the health screener as early as 1982. The 1999 Evaluation Report described how, on occasion, the GMC had delayed in appointing examiners and in dealing with problems which had arisen between examiners and doctors. Doctors had sometimes failed to respond promptly and had missed appointments. In four of the 40 cases, the reports of the medical examiners had not been received for as long as three to six months after the examination. There had also been difficulties and delays in appointing medical supervisors.
- 22.86 The 1999 Evaluation Report pointed out that doctors were free to practise during the period of referral into medical supervision and that patients might therefore be at risk during that time. It recommended that the GMC should introduce a computerised system for processing complaints and for recording the progress of each case through the health procedures. It also recommended that the GMC should follow up the initiation of the arrangements between doctors and examiners to ensure that appointments had been made and examinations had taken place. Examiners who exceeded the target times for submitting reports should be followed up. Also, if an examiner failed to provide requested information s/he should be required to do so. If the GMC found that an examiner persistently failed to meet target times or to provide required information, the use of that examiner should be discontinued. The GMC should monitor the quality of supervision provided and should replace a supervisor where supervision was poor.
- 22.87 In response to this Report, in July 2000, the GMC introduced service standards, which effectively tackled the problems of delay. These standards were updated in April 2003. The 2003 standards allowed about one month for screening, two months for examinations and two months for decisions to be taken. By then, either the doctor would have accepted voluntary undertakings or s/he would have been referred to the HC. Thus, within five months of receipt, a health case should either have been closed or action would have been taken. In December 2003, the GMC achieved this target in 86% of cases, just short of the target of 90% which it had set for itself. In the event that patients were thought to be

at risk, there was the option of referring the case to the IOC. The 2003 service standards required all cases referred to the IOC to be heard within one month. These service standards had the effect of substantially 'tightening up' the health procedures.

### **Supervision of Doctors in the Voluntary Health Procedures**

- 22.88 As I have said, the 1980 Health Rules contained no specific provision for the supervision of doctors who had entered the voluntary health procedures. In practice, however, doctors entering the voluntary health procedures were always required to undertake to accept medical supervision. Rule 9 of the 1987 Health Rules formalised this practice. It gave the health screener power, in a case which was being dealt with under the voluntary health procedures, to request one or more medical practitioners to supervise the management of the doctor's case and to report if necessary on the doctor's observance of his/her undertakings and on his/her fitness to practise. The purpose of this supervision was to satisfy the health screener that the doctor was observing his/her undertakings.
- 22.89 The health screener would select a suitable medical practitioner to supervise the doctor. The medical supervisor might be one of the practitioners who had examined the doctor on behalf of the GMC. He or she might be a practitioner who was already treating the doctor. The role of the medical supervisor was to monitor the doctor's progress and fitness to practise and to report to the GMC. The medical supervisor was also required to ensure that the doctor was getting the support and treatment necessary to assist his/her recovery. The supervisor also had to ascertain whether the doctor was complying with his/her undertakings; s/he did this by carrying out tests for the presence of alcohol and drugs and by collecting information from independent informants and other treating doctors. The frequency of contact between the doctor and his/her medical supervisor was a matter for the supervisor him/herself.
- 22.90 If the doctor was continuing to practise, the GMC would require a professional supervisor to be appointed. The professional supervisor was selected by the doctor (in consultation, if applicable, with his/her employer). The GMC did not dictate who should fulfil this role. It was to be someone in a senior position who had personal experience of the doctor's work. If the doctor was a GP, it could be the senior partner of the GP practice in which the doctor worked. Dr Mann said that it was easier to get objective feedback if a doctor was working in an organisation or in a hospital, because the doctor would be coming into contact with more people. If s/he was a GP, it was necessary to rely on partners, who might have mixed feelings about the doctor practising, or on a colleague in an organisation such as a LMC or PCT. That person would be working at a distance and would not have the same personal contact with the doctor. Dr Mann said that, if someone within a GP practice was willing to give information about the doctor's progress, the information which s/he was able to give was likely to be valuable, since it would be based on close contact with the doctor.
- 22.91 It seems to me that the difficulty of obtaining reliable information about the doctor's work represented a weakness in the old health procedures. The health screener really did need to have personal contact with someone who saw the doctor regularly. The screener needed to have some 'feel' for the level of concern which there was about the doctor's practice. I can understand why the health screeners did not establish personal contact



with the doctor under supervision; they needed to remain at arm's length. However, the screeners did need a source of information close to the doctor and this was not always available.

- 22.92 In a case of substance abuse, the medical supervisor was expected to report to the GMC any lapse in the doctor's behaviour which might affect his/her fitness to practise. The GMC would request progress reports. Dr Mann said that the first report was usually requested three to six months after the doctor was put under supervision. A second report was requested after a further period of about six months. Thereafter, the timing was variable according to circumstances and the recommendations of the medical supervisor. Sometimes, the GMC would receive an unsolicited report from a medical supervisor. This might give news of a change for the worse, but would sometimes inform the GMC of a change for the better and would suggest that the doctor's undertakings should be relaxed. When the GMC requested a progress report, its letter of request would include a list of questions to be answered and the supervisor would be asked to collect information from various sources and to include that information in his/her report. The supervisor would also be asked for his/her views about whether the GMC should conclude the case, or whether the doctor required further monitoring.
- 22.93 Health screeners had no personal contact with the doctor concerned and were entirely reliant on the medical supervisors to keep in regular contact with the doctor, to collect information about him/her and to be rigorous in carrying out objective testing, where appropriate, for alcohol or drugs. The availability of testing of hair (which can reveal the presence of opiates as long as three months after ingestion) and the carrying out of random tests were, according to Dr Mann, valuable tools in the supervisory process. Usually, there would be no direct communication between the health screener and the professional supervisor. The latter would provide information to the medical supervisor.
- 22.94 Dr Mann emphasised that the role of the medical supervisor was an onerous, although rewarding, one. It involved a great deal of responsibility, both to the public and to the profession. It was not well paid. Dr Mann said that many medical practitioners regarded it as their duty to contribute to the wellbeing of the profession by acting as GMC supervisors. However, some doctors found it difficult to treat other doctors.

### ***The Treating Doctor as Medical Supervisor***

- 22.95 The 1999 Evaluation Report expressed concern about the fact that, in 22 out of the 40 cases in which the reports of medical supervisors were examined, the supervisor had been a practitioner who was already treating the doctor. The Report observed that this duality of roles increased the difficulty for a medical supervisor in balancing the interests of the doctor and of the wider patient population. It recommended that, save in exceptional circumstances, the GMC should not appoint a treating doctor as the medical supervisor.
- 22.96 Dr Mann said that most cases in the voluntary health procedures involved mental illness, alcoholism, drug abuse or a combination of more than one of these features. Usually, therefore, the medical supervisors would be psychiatrists. In general, the health screeners would try to appoint a medical supervisor who was not the treating psychiatrist. However, the position was rather different with cases of substance misuse. Dr Mann said that there

had been much debate about the advantages and disadvantages of combining the roles of treating psychiatrist and medical supervisor in cases of substance misuse. The problem with combining the two roles was that the psychiatrist might be subject to a conflict of loyalties, as between the doctor, the GMC and the public. It might be difficult to cope with that conflict. The second problem was the feeling that a medical supervisor who was also the treating psychiatrist might not be truly independent.

- 22.97 Dr Mann explained that, on the other hand, there were distinct advantages in combining the two roles. First, there were comparatively few practitioners who specialised in substance misuse. General psychiatrists often lacked the necessary expertise and were not able to offer the same help and support to sick doctors, whether as treating psychiatrist or as supervisor. If the doctor was already receiving treatment from an expert in substance misuse, it was less wasteful of resources, and might be more beneficial to the doctor, to appoint that person as supervisor also. A second reason for combining the two roles was to ensure that all the information which should be communicated to the GMC was known to the supervisor. As I have explained, the medical supervisor was expected to report to the GMC any lapse in the doctor's behaviour of which s/he was aware. If the supervisor was not the treating doctor, s/he would be reliant upon the treating doctor to pass on information about, for example, a return by the doctor to taking alcohol or drugs. Dr Mann said that it was easier for one person to have 'all the reins in their hands'. Conversely, there could be a problem if the doctor under supervision did not confide fully in his/her treating doctor because that doctor also took a supervising role. I suspect that there is no perfect answer to this problem.

### ***Problems with Medical Supervisors' Reports***

- 22.98 I have explained that the King's College team examined a sample of reports submitted to the GMC by medical supervisors in the cases of 40 doctors who had been placed under medical supervision in the period 1989 to 1996. The 1999 Evaluation Report pointed out that the supervisors' progress reports were the GMC's principal source of information about the doctor's fitness to practise.
- 22.99 Delay was one feature noted by the King's College team. In 16 out of the 40 cases, one or more reports was explicitly described in the case notes as being late or having been the subject of repeated requests that it should be provided. In 18 cases, the first progress report was received more than two months after the time for which it had been requested. Delays had been caused by doctors failing to make arrangements with supervisors, by the time taken to obtain information from independent informants and by the time taken by supervisors in responding to requests for reports. There were also significant delays in the provision of subsequent progress reports. Because of the long intervals between reports, three out of the 40 cases had been concluded after only two reports from the medical supervisor had been received. In one case, no reports at all had been received.
- 22.100 In 16 of the 40 cases, significant information was missing from the supervisor's report. This mainly related to the doctor's fitness to practise, often because of a lack of information from an independent person about the doctor's performance of his/her professional practice. Sometimes, supervisors were reluctant to approach the doctor's colleagues. In

some cases, there were no results of tests for the presence of alcohol or drugs, often because the supervisor was reluctant to conduct random testing. One supervisor observed that s/he did not wish to **'act like a detective'**. Missing information was sometimes recorded in later reports, but this might be as long as 9 to 16 months later. Sometimes, it was never provided. One case was concluded after three years without the results of any testing having been received. The supervisor had repeatedly claimed that he was **'working on an arrangement to carry out random testing'**. In a few cases where the relevant information was not available, the GMC had varied the doctor's undertakings in an attempt to prevent risk to patients. Three of the sample cases had been closed without receipt of the requested information to support a conclusion that the doctor was fit to practise.

- 22.101 In 11 out of the 40 cases, the file disclosed dissatisfaction on the part of the health screener with the medical supervisor's management of the doctor under supervision. There were references to problems with the content and timeliness of reports, to the supervisor's failure to enforce the restrictions on the doctor's practice and to breakdowns of communication or loss of contact between supervisors and doctors. In six of the 11 cases, the issue was an isolated incident, which was resolved. However, in five cases, there was more enduring concern or criticism. A change of supervisor was often considered in cases where there was dissatisfaction with the existing regime. However, no change was implemented in any case. The reason for this was sometimes the practical difficulties involved in finding a replacement supervisor. However, arguments presented by the supervisor and the doctor about the benefits of their continuing therapeutic relationship were often accepted as reasons for continuing an otherwise unsatisfactory supervisory relationship.
- 22.102 The 1999 Evaluation Report recommended that the GMC should actively pursue information which was not provided in supervisors' reports and should reach clear agreements with supervisors about the undertaking of testing for alcohol and drugs. It also recommended that greater emphasis should be given to monitoring the quality of supervision and to replacing a supervisor who did not comply with the GMC's requirements.
- 22.103 Mr Howes said that, in the early days of the health procedures, there was considerable reluctance on the part of medical supervisors to subject doctors to random drug testing for alcohol and other drugs. He said it 'went against the grain' for doctors to impose such procedures on their patients. There was also a degree of scepticism about the usefulness of such tests. More recently, however, the GMC had become much firmer with supervisors. If they did not co-operate, they were no longer used. Dr Mann agreed that the GMC was now much more rigorous in the requirements it made of supervisors. All supervisors in cases of substance abuse were required to ensure that objective testing for the presence of alcohol and other drugs was carried out periodically and to provide the GMC with the results of those tests. If they refused to do this, or if they did not comply with other GMC requirements, they could be removed from a specific case, or from the GMC's list generally. Dr Mann said that this had happened 'perhaps not as often as perhaps it should have done', but it had happened from time to time. There was a greater insistence

on progress reports being provided promptly and on the information which should be contained in such reports.

22.104 In addition, the GMC had established closer links with its supervisors and medical examiners. A leaflet explaining the role of the medical supervisor and his/her responsibility for managing a sick doctor had been produced. In October 1998, the first training day for medical supervisors and medical examiners was held. This was followed by a series of training days and workshops. Dr Mann said that the meetings with medical examiners and supervisors had provided a valuable opportunity to exchange views about problems and to discuss possible solutions to those problems. It had given 'a sense of coherence'. There had been useful discussions about, for example, the advantages and disadvantages of appointing as medical supervisor a substance misuse specialist who was already treating the doctor. Dr Mann said that, over recent years, the GMC had moved towards appointing supervisors as a cohort of practitioners who understood the GMC's procedures and who recognised that a slightly different approach was required when supervising a doctor from that which was usual when just treating the doctor. There had also been attempts to use medical examiners as supervisors in order to promote a greater understanding of the GMC's procedures and requirements. At the time Dr Mann gave evidence to the Inquiry, in December 2003, there had been no meetings with medical examiners or supervisors for a year or so. The Health Section was waiting until the arrangements for dealing with health cases under the new procedures were clear before organising any further meetings.

#### **Action on Receipt of a Medical Supervisor's Progress Report**

22.105 During the early stages of a doctor's supervision, if it appeared from the medical supervisor's report that s/he was complying with his/her undertakings and appeared to be making progress, the undertakings might be left unchanged.

#### ***Variation of the Doctor's Undertakings***

22.106 However, there might have been circumstances which made it appropriate for the undertakings to be relaxed or strengthened. Rule 9 of the 1987 Health Rules introduced a power to vary a doctor's undertakings. If, as a result of a report from a medical supervisor or of information from another source, it appeared to the health screener that the terms of the doctor's undertakings should be varied, the health screener could invite the doctor to agree to that.

22.107 Dr Mann said that, although each case was different, the normal pattern in an 'average case' was for undertakings to be relaxed gradually to give the doctor more freedom in his/her choice of job and, if his/her right to prescribe had been restricted, by relaxing that restriction. This type of relaxation might happen two or three times over a period of two years before the doctor was considered fit to practise unsupervised and unrestricted.

22.108 It is clear from the Annual Reports of the health screener that, in the early 1990s, the health screeners made use of their power to vary undertakings by making them more stringent. For example, the Annual Report for 1990 recorded that the first action of the health

screeners after a breach of a doctor's undertakings had been identified was to send **'a firm letter'** to the doctor, tightening the restrictions on his/her practice. By the late 1990s, however, the GMC had come to believe that the powers to vary undertakings did not include the power to make them more stringent. Later, this view changed again and, where the circumstances made it appropriate, a doctor would be invited to agree undertakings that imposed greater requirements or restrictions on him/her than had originally been the case. Dr Mann said that the perceived inability to tighten an undertaking had been a limiting factor. The health screener might have wished to stop a doctor doing on-call work or from working as a locum but had been unable to make the necessary change without referring the doctor to the HC. This was a cumbersome and time-consuming process.

### ***Cessation of the Doctor's Undertakings***

22.109 Rule 9 of the 1987 Health Rules also provided that the health screener might direct that the undertakings should no longer apply, thus bringing the period of the doctor's supervision, and any limitations on his/her practice, to an end. The time at which this happened depended on the nature of the impairment. In cases of substance misuse, Dr Mann said that it would be unusual for a doctor to be released from his/her undertakings within two years after first being put under supervision. If the doctor suffered a recurrence of his/her problem or a relapse, the period of his/her supervision was likely to continue for as long as five years. Supervision might continue for the whole of the doctor's professional life if, as sometimes happened, it appeared to be the fact of supervision (and the threat of action by the HC) that kept the doctor on the 'straight and narrow'. More usually, as I have said, there would be a gradual relaxation of the limitations upon the doctor's practice over a period of years before a final decision was taken that the doctor was fit to practise unsupervised.

22.110 The evaluation by the King's College team of the 40 sample cases from the period 1989 to 1996, in which the doctors had been dealt with under the voluntary procedures, revealed two main criteria used by the health screener when assessing whether a doctor should be released from his/her undertakings and permitted to practise unsupervised. The first criterion was a substantial and consistent improvement in the doctor's health, with evidence that the doctor had been abstinent from alcohol or drugs for a significant period of time (usually, two years). The second criterion was a proven record of the doctor's ability to maintain good clinical performance. The 1999 Evaluation Report recorded, however, that the team's examination of the sample cases suggested that, on occasions, cases had been concluded without substantial evidence of improvement or abstinence. Sometimes, they were concluded on the 'condition' (which would not have been enforceable) that the doctor should remain under the care of the medical supervisor. The King's College team found that the average time for which a doctor remained under supervision during the period 1980 to 1996 was three and a half years. It seems to me that 'proof' that the doctor had maintained good clinical performance might, in some cases, be hard to find. I have mentioned that, for doctors who are not working in a managed employment environment, it might be difficult to find a professional supervisor who had close contact with the doctor. For example, if the professional supervisor of a GP were a colleague on the LMC or at the

PCT, it might not have been possible for the health screener to obtain satisfactory information about the GP's clinical performance.

## The Statistics

- 22.111 Between 1980 and 1990, the number of doctors referred to the Health Section annually was in general between 40 and 60. Between 1991 and 1994, it varied between 71 and 87. In 1996, it reached three figures for the first time. A serious backlog of cases developed in 1996/1997 which necessitated the recruitment of additional staff. The number of referrals dealt with by the Health Section reached a peak of 188 in 2000 and 181 in 2001. In the last two years, the referral rate dropped; 104 doctors were referred in 2002 and 124 in 2003.
- 22.112 Meanwhile, the number of doctors under supervision has risen. Between 1985 and 1990, it remained steady at between 60 and 68. It rose to 78 in 1991 and, by 1995, had almost doubled to 147. By 1998, 202 doctors were under supervision. Since then, the number has changed little. The 2003 FTP statistics show that 212 doctors remained under supervision in the voluntary health procedures, of whom 54 were GPs. About 100 doctors remained under the jurisdiction of the HC.

## The Health Committee

### Referral to the Health Committee by the Health Screener

- 22.113 I have already said that a doctor could be referred to the HC if s/he refused to undergo, or failed to co-operate with, a medical examination or if s/he failed to agree to undertakings or was unfit to agree to or to comply with undertakings. In addition, s/he might be referred to the HC for breach of an undertaking or if his/her condition deteriorated.
- 22.114 If the health screener learned from the report of a medical supervisor, or by way of information from some other source, that the doctor had ceased to observe an undertaking previously given, the health screener might refer the case to the HC. From 1987, a referral could also be made if the doctor's physical or mental condition had deteriorated. Until November 2002, referral to the HC was subject to consultation with two members of the 'panel of six'. After that time, the health screener was able to initiate a referral without a requirement to consult. In practice, however, the health screener would usually consult with the doctor's medical supervisor when deciding whether to refer a case to the HC.
- 22.115 The number of doctors referred to the HC annually was always relatively small. There were few referrals to the HC from the other FTP committees. Most referrals came from the health screener. The most common reason for a referral to the HC was a failure, at some point in the doctor's time in the voluntary health procedures, to comply with his/her undertakings.
- 22.116 In the past, there had appeared to be reluctance on the part of the health screeners to respond to a breach of a doctor's undertakings by referring the doctor to the HC. In the early 1990s, it was said in an Annual Report of the health screener that a doctor would be referred to the HC only if s/he persistently broke his/her undertakings. There was mention

in the Annual Reports also of a perception on the part of the health screener that it was his role to prevent doctors from being referred to the HC. I can appreciate that the aim of the health screener should have been to achieve a doctor's rehabilitation within the voluntary procedures wherever possible. However, the health screener should also have been prepared to refer to the HC a doctor who was not complying with conditions that had been imposed to assist in his/her recovery and/or for the purpose of protecting patients.

- 22.117 The King's College team found that just over half of doctors identified as having been dealt with under the voluntary health procedures had been reported for breach of one or more of their undertakings. The 1999 Evaluation Report pointed out that this was likely to be an underestimate of the actual incidence of breach. A large proportion of the doctors reported to have breached their undertakings had been working at the time of the breach. Some had breached undertakings to seek the advice of their supervisor before taking up or applying for a post. Some had practised as a locum or single-handed GP in breach of an undertaking not to do so. The most commonly reported breach was of the undertaking by a doctor to abstain from, or limit his/her intake of, alcohol. The number of reported breaches was less in the period from 1989 to 1996 than in the period from 1980 until 1988. Over the whole period from 1980 to 1996, 73% of the doctors who breached one or more of their undertakings had been judged by the medical examiners as fit to practise with restrictions. The 1999 Evaluation Report drew attention to the potential risks to patients caused by doctors who were in practice but were failing to comply with their undertakings.
- 22.118 Mr Howes said that, during his second period in the Health Section (1997 to 2001), the health screeners had 'tightened up considerably' in respect of breaches. Even so, not every breach of an undertaking resulted in a referral to the HC. Mr Howes said that each case would have to be judged on the seriousness of the breach, whether patients were put at risk, whether the doctor had practised a deception, or whether s/he had immediately afterwards admitted the breach. The supervisor and the screener would come to a view about the seriousness of the breach.
- 22.119 Between 1980 and 1997, the number of doctors referred to the HC by health screeners in any one year never reached double figures. The most common reason for referral was breach of the doctor's undertakings. In 1998, the number of doctors referred to the HC by the health screeners rose sharply to 21. Fourteen of those referrals were for breach of undertakings. Dr Mann said that she was not sure that there had been a conscious change of policy at that time. However, there was an awareness of concern about leniency and she thought that the health screeners had been 'a little bit stricter' when dealing with breaches of undertakings. She felt that, previously, the GMC had been 'more easy going' with supervision. In 1999, the health screeners referred 16 doctors to the HC; in 2000, they referred 37. The figures for 2001, 2002 and 2003 were 19, 21 and 17 respectively.

#### **Referral from Other Fitness to Practise Committees**

- 22.120 A case might be referred to the HC by the PCC, the Assessment Referral Committee (ARC), the Committee on Professional Performance (CPP) or the PPC.
- 22.121 As I explain in Chapters 21 and 24, where, in the course of their consideration of a case, a question arose as to whether a doctor's fitness to practise might be seriously impaired



by reason of his/her physical or mental condition, the PCC, the ARC and the CPP had power to refer the case in question to the HC for determination. The doctor would be examined and the HC, having considered the results of the examination, would certify its opinion to the relevant Committee. If the HC took the view that there was no serious impairment of fitness to practise due to ill health, the referring Committee would then resume its consideration of the case and would dispose of it. If, on the other hand, the HC's opinion was that the doctor's fitness to practise was seriously impaired as the result of ill health, the HC would then deal with the case itself and the referring Committee would cease to exercise any functions in relation to the case. By referring a case to the HC for its opinion, the PCC, the ARC and the CPP did not necessarily lose their jurisdiction over the case. If no serious impairment was found, they could proceed to deal with it. None of these three Committees could refer a case to the voluntary health procedures.

22.122 The position was different with the PPC. The PPC, using its power to adjourn, was able to refer cases into the voluntary health procedures. It also had the power to refer cases direct to the HC. However, if it made such a referral and the referral proved inappropriate for some reason (e.g. because, on examination, no – or no serious – health problem was identified), the HC could not take action itself, nor could it refer the case back to the PPC. In such a case, the GMC was powerless to act, even if there was evidence of misconduct (or a conviction) which would have merited action under the conduct procedures.

### **The Procedure Which Was Adopted**

22.123 Rules 11 and 12 of the 1987 Health Rules set out the procedure to be adopted when a decision had been taken to refer a case to the HC. Under rule 11, it was open to the health screener to invite the doctor to undergo medical examination before his/her case was considered by the HC. The medical examination would be conducted by one or more medical examiners selected by the GMC and, if the doctor chose, by a medical examiner selected by him/her. If the doctor agreed to be examined, the GMC staff would make the necessary arrangements. The object of this provision was to ensure that the HC had medical evidence when it came to consider the case. The health screener could take these steps, not only when s/he had taken the decision to refer the doctor's case to the HC him/herself, but also when that decision had been taken by the CPP, the ARC, the PPC or the PCC.

22.124 Rule 12 required the Registrar to serve on the doctor a 'notice of referral', containing certain specified information. That information included an indication of the physical or mental condition by reason of which it was alleged that the doctor's fitness to practise was seriously impaired.

### **The Powers of the Health Committee**

22.125 The powers of the HC were contained in section 37 of the 1983 Act, which virtually reproduced the provisions of section 8 of the 1978 Act. Section 37(1) provided:

**'Where the fitness to practise of a fully registered person is judged by the Health Committee to be seriously impaired by reason of his physical or mental condition, the Committee may, if they think fit, direct -**

**(a) that his registration in the register shall be suspended (that is to say shall not have effect) during such period not exceeding twelve months as may be specified in the direction; or**

**(b) that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements so specified as the Committee think fit to impose for the protection of members of the public or in his interests.'**

### **The Composition of the Health Committee**

22.126 The composition of the HC was governed successively by the General Medical Council (Constitution of Fitness to Practise Committees) Rules Order of Council 1980, 1986 and 1996 (the Constitution Rules). Between 1980 and 1996, the HC was composed of the Chairman, the Deputy Chairman, nine medical members and one lay member of the GMC (i.e. 12 members in all).

22.127 The 1980 and 1986 Constitution Rules provided that the President should choose whether he wished to chair the HC. If he chose not to do so, he was required to appoint another member of the GMC as Chairman. The President was also required to appoint a Deputy Chairman. Both appointments were subject to the approval of the Council. Other members of the HC were elected by the Council annually. The legal quorum of the HC was five.

22.128 In 1996, membership of the HC was reduced from 12 (including the Chairman) to nine. Seven members of the PPC were to be medical members and two were to be lay members. The Constitution Rules continued to provide that the HC should be chaired by the President or, if he chose not to act in that capacity, by another member of the GMC appointed in his place. If neither the Chairman nor the Deputy Chairman of the HC was available to chair a meeting, the President had the power to appoint another member of the HC to act as Chairman. From 1996, the legal quorum for the HC was five, including one lay member. In November 2002, the quorum was reduced to three, to include at least one medical and one lay member.

22.129 As I have explained in Chapter 15, in 2000, the GMC was given the power to co-opt non-GMC members, both medical and lay, to sit on its FTP committees. A pool of such persons, who were known first as 'adjudicators', then as 'associates', was recruited. Initially, associates would sit alongside GMC members of the HC on panels to consider cases. After July 2003, panels of the HC would usually consist entirely of associates.

### **Meetings of the Health Committee**

22.130 The HC sat in private and was advised by a legal assessor and two medical assessors. In general, one of the medical assessors would be a practitioner from the doctor's own specialty and the other would practise in the specialty relating to the physical or mental condition from which the doctor was alleged to be suffering. This assessor was usually a psychiatrist. The doctor was entitled to be present and might be legally represented. He or she might also be represented or accompanied by an officer of his/her medical defence organisation, or some other professional organisation of which s/he was a member, or by

a member of his/her family, or by a friend, and might also be accompanied by his/her medical adviser. After 1987, the complainant (if any) was entitled to appear before the HC and to be represented. However, s/he was not entitled to receive any medical reports or information concerning the medical condition of the doctor which the GMC may have obtained, and was excluded from the hearing save for the purpose of giving evidence and hearing the HC's decision. In practice, complainants rarely, if ever, appeared.

- 22.131 The GMC's representative would then present the case and call witnesses to give oral evidence. The 1987 Health Rules introduced a provision enabling the doctor to request that the author of any document to be considered by the HC should be called as a witness. The complainant (if any) or his/her representative would be invited to address the HC. The doctor or his/her representative was then permitted to address the HC and to adduce evidence as to the doctor's fitness to practise. The GMC's representative would then be invited to address the HC, with the doctor or his/her representative having the last word.

### **Adjournment or Postponement**

- 22.132 At the conclusion of the proceedings, the HC might adjourn the case in order to obtain further medical reports or other information as to the physical or mental condition of the doctor or in relation to his/her fitness to practise. If the HC did not think it appropriate to adjourn the case, it had to consider whether to postpone its finding as to the doctor's fitness to practise. The power to postpone its finding was introduced by the 1987 Health Rules. The purpose of this power was to enable the HC to place a doctor 'on probation' on the basis of undertakings given by the doctor to the HC, thus avoiding the need to impose formal conditions or to suspend registration. It does not seem that this power was ever exercised.

### **Sanctions**

- 22.133 If the HC did not consider it appropriate to adjourn the case or to postpone its finding, it had to consider and determine whether the doctor's fitness to practise was seriously impaired by reason of his/her physical or mental condition. If the HC found no serious impairment of the doctor's fitness to practise, it had no power to take any further action. The 1987 Health Rules provided that, in reaching its judgement, the HC should be entitled to regard as a current serious impairment not only the doctor's current physical or mental condition but also a continuing and episodic condition, or a condition which, although currently in remission, might be expected to cause recurrence of serious impairment. In 2003, the HC found that there was no serious impairment of the doctor's fitness to practise in 17 out of 141 cases.
- 22.134 In a case where the doctor had refused a medical examination or had failed to submit to examination, the HC was entitled, if it thought fit, to find that his/her fitness to practise was seriously impaired on the basis of the information which was available to the HC, together with the doctor's refusal or failure to submit to examination.
- 22.135 If the HC judged that the doctor's fitness to practise was seriously impaired, it had next to consider and determine whether it was sufficient to direct that the doctor's registration

should be conditional upon his/her compliance with such requirements as the HC might think fit to impose either for the protection of members of the public or in the doctor's own interests. Such requirements would always include a condition that the doctor must accept medical supervision, and might also include limitations on the doctor's practice and conditions relating to medical treatment. The doctor's consent was required to any conditions relating to the medical management of his/her case. The HC was required to specify a period for which the conditional registration should last; the period could not exceed three years. If the HC decided that it was not sufficient to impose conditions on the doctor's registration, it was required to direct that his/her registration should be suspended for a period not exceeding 12 months. In an appropriate case, the HC could order that the suspension should take place immediately, rather than being delayed until the expiration of the appeal period, or, if an appeal was lodged, until determination of the appeal. The HC had no power to refer a doctor back into the voluntary health procedures.

### **The Decision of the Health Committee**

22.136 Decisions of the HC were taken on the basis of a simple majority. If the votes were equal, the question at issue had to be determined in favour of the doctor concerned. The 1987 Health Rules provided that the Chairman should announce the determination or determinations of the HC **'in such terms as the Committee may approve'**. For many years, the HC gave no reasons for its decisions. More recently, the HC included in its decisions an indication of the condition that was seriously impairing the doctor's fitness to practise, together with an explanation for the sanction imposed.

### **Resumed Hearings**

22.137 In a case where the HC had directed that the doctor's registration should be suspended or made subject to conditions, it was required, when announcing its decision, also to indicate that it would resume consideration of the case before the end of the period of suspension or conditional registration. In preparation for the resumed hearing, the HC would require a report from the doctor's medical supervisor and, possibly, from the treating doctor. The HC might also require the doctor to submit to further medical examination before the resumed hearing. The necessary arrangements for a resumed hearing were made by the GMC staff, acting under the instructions of the health screener. In the meantime, it was usual for the health screener to request interim reports from the doctor's medical supervisor, together with the results of testing. If the health screener received information that the doctor was failing to comply with the conditions previously imposed on his/her registration or that there was a reason for varying the conditions, s/he might refer the case for an early resumption of the hearing.

22.138 When the HC had suspended a doctor's registration, it could, at a resumed hearing, direct a further period of suspension not exceeding 12 months, to start immediately after the first period had expired. Alternatively, it could direct that the doctor's registration be subject to conditions from the expiry of the period of suspension. It could direct that the conditions should remain in place for a period not exceeding three years.

22.139 Where the HC had imposed conditions on a doctor's registration, it could, at a resumed hearing, direct that the period of conditional registration should be extended for a period

of not more than 12 months at a time. The HC also had power, at a resumed hearing, to vary or revoke any of the conditions imposed. If the HC judged that the doctor had failed to comply with any of the conditions, it might direct that his/her registration should be suspended for a period not exceeding 12 months.

### ***Indefinite Suspension***

22.140 Over the years after the inception of the health procedures, the number of doctors under the jurisdiction of the HC increased steadily. Some doctors suffered from chronic conditions and were unlikely to be fit to return to practice for many years, if ever. Until 1996, the only course open to the HC when dealing with such doctors was to suspend them for 12 months, to bring them back for a review of their case towards the end of the period of suspension and then to suspend them again. This created an unnecessarily heavy workload for the HC, was wasteful of resources and could be very stressful for the doctor concerned. The HC explored various possible strategies for eliminating this problem; it proposed a form of shortened hearing and the use of conditional registration in place of suspension. It also suggested that it should have the power to impose longer periods of suspension. In 1996, the problem was solved when the HC acquired the power to suspend a doctor indefinitely. This power could be exercised when the doctor had already been suspended for two years or more. The doctor could apply for review of a direction for indefinite suspension, but not before two years after the date on which it took effect and then not more than once in any period of two years. The power to impose indefinite suspension enabled the HC to conclude some of its most intractable cases. Between 1996 and 2003, about 50 doctors were suspended indefinitely.

### **Appeals**

22.141 Appeals from decisions of the HC were governed by section 40 of the 1983 Act. Until April 2003, a doctor who was the subject of a direction for suspension or for conditional registration (or variation of the conditions imposed by a direction for conditional registration) had a right of appeal to the Judicial Committee of the Privy Council. From April 2003, appeals lay to the High Court. Until 2003, an appeal lay on a question of law only. In 2003, that restriction was removed.

## **The Operation of the Health Procedures**

### **Integration of the Health Procedures with the Other Fitness to Practise Procedures**

22.142 Mr Howes said that it was a relatively rare occurrence for a doctor who was being dealt with in the voluntary health procedures to be the subject of a subsequent report of potential misconduct. If such a report was received, his own 'instinct' would have been to look for a health element, related to the doctor's illness, which might have accounted for the alleged misconduct. If no such link had been apparent, he would have recommended conduct action. If there had appeared to be any linking factor, he said that he would have 'left it to the health and conduct screeners to fight it out as to which route the case ought to go down'. It was very rare for a doctor to have a health and conduct case progressing at the same time.

22.143 If a case was progressing through the performance procedures and health concerns arose that warranted referral into the health procedures, the performance action would be 'frozen'. Conversely, if a case gave rise to concerns about both health and performance, it would be assumed that the performance problems were health-related. There would not be a referral into the performance procedures. Once the doctor had regained his/her health, an attempt would be made to ease him/her back into practice after a programme of retraining organised by the local postgraduate dean but no performance assessment would be carried out.

### **Views about the Old Health Procedures**

22.144 Dr Mann said that she certainly did not consider referral into the voluntary health procedures to be a 'soft option' compared with referral into the conduct procedures. The voluntary health procedures could last for years, even for the remainder of the doctor's professional life. The undertakings were often quite stringent, with considerable obligations on the doctor to adhere to them. She said that at the back of everyone's mind was the fact that, if the doctor did not adhere to the obligations under the voluntary procedures, then s/he could be referred to the HC which might lead to indefinite suspension.

22.145 Mr Howes emphasised that, at the time he worked in the Health Section, it did not appear to him that the voluntary health procedures were a 'soft option' when compared with the conduct procedures. He conceded that a doctor whose case was being dealt with under the voluntary health procedures was not at risk of erasure. However, he pointed out that, if a doctor was referred to the PCC, he might be admonished, judgement might be postponed or s/he might have his/her registration suspended for a short time. Even if his/her name were erased from the register, s/he might be restored 'a couple of years later' (this was at a time when the first application for restoration could be made ten months after erasure, so that even a doctor who made one unsuccessful application could still be restored on his/her second application within two years). By contrast, the HC had no power to admonish. Consequently, virtually every case where a serious impairment of fitness to practise was found resulted in the suspension of, or the imposition of conditions on, the doctor's registration. In most cases, the doctor would come back before the HC on one or two occasions and would be dealt with by way of further suspension or conditions. Indefinite suspension had also been available latterly. Mr Howes said that he thought the HC was 'quite a tough Committee now'. It had 'learnt to bite the bullet'. He observed:

**'Even though it is comprised principally of doctors, they have learnt that they are not just treating a sick doctor, they are protecting the public and they grasped that fairly early on in the 1980s. It was a culture shock for a Committee of doctors but they grasped it fairly early on and learnt that it even helps the doctor to impose some sort of sanction in many cases.'**

22.146 Dr Mann identified as one of the strengths of the health procedures the fact that they had been acceptable to a large number of (although not all) doctors whose health was at one time or another called into question. She felt that the procedures provided a real incentive to remain abstinent from drink or drugs because of the implications of suspension on a

doctor's livelihood. She also felt the GMC had developed a good network of competent specialists to examine and supervise sick doctors. It was also achieving a quick turnaround of cases.

- 22.147 Dr Mann perceived the main weakness of the health procedures to be their separation from issues of performance. There was a need to monitor both simultaneously. She said that it would be nice to have some 'easy assessment' of a doctor's performance that could tie in with health and other issues. The GMC's full performance assessments, although detailed and helpful, took a long time and were cumbersome and expensive in terms of both money and doctors' time. She said that, if appraisal produced hard evidence about a doctor's performance following assessment, that might solve the problem. However, it seems to me that the problem will not be solved in that way, at least so far as GPs are concerned. At present, the appraisal of GPs does not include any form of assessment.
- 22.148 Mr Howes said that the rehabilitation of sick doctors was a problem. If a doctor had been compelled to give up work as a result of his/her illness (whether voluntarily or as a result of suspension), s/he might be 'rusty' by the time s/he was fit to return to work. Often, a doctor would wish to change specialties at that point and might need to learn new skills in order to do so. Mr Howes said that the GMC was very conscious of the problem and would have liked to have seen a system (perhaps a NHS system) whereby such doctors could receive 'refresher training' in their own specialty, or be retrained in a different specialty. As it was, the GMC would rely on the postgraduate deans to devise *ad hoc* refresher schemes for doctors who were re-entering the same specialty as previously. The position of a doctor who wished to change specialty was more difficult. Over the years, the GMC has encouraged initiatives such as the introduction of local liaison advisers to support doctors in their rehabilitation and the provision of supernumerary posts without clinical responsibility for the retraining and rehabilitation of doctors recovering from a period of illness. However, these schemes can only cater for a few and there are still serious problems in managing the rehabilitation of doctors who have been absent from work for some time and have become de-skilled as a result.
- 22.149 Dr Mann said that the solution to the problem of rehabilitation varied from case to case. It depended on which part of the country the doctor was in. If a doctor was off work for some time, efforts would be made to organise a training programme. A hospital doctor might be able to take up a supernumerary post while being assessed. However, such a post was not always available and, even if it was, the supervision and assessment might not be of good quality. The local postgraduate deans might be involved but they were 'under pressure'. It seems to me that the lack of any assessment to ensure that a doctor's clinical performance and competence were satisfactory before s/he was allowed to return to practice after a period of ill health was a real *lacuna* in the operation of the health procedures.

### The Inquiry's Examination of Cases

- 22.150 As I have said, both Dr Mann and Mr Howes were of the view that the health procedures were working well, provided a proper degree of protection to patients and public and were not a 'soft option' for doctors. In order to test these views, the Inquiry considered a large



number of files of cases which had entered the health procedures. Some were discussed during Dr Mann's evidence. The Inquiry was, of course, interested in cases that bore some resemblance to that of Shipman in 1976. I particularly wished to explore the interaction of the conduct and health procedures in cases which involved elements of misconduct and ill health.

### **Cases Closed by the Health Screeners**

22.151 The Inquiry considered sixteen cases which had been closed by Dr Mann between 2000 and 2003. None of those cases gave rise to any concern that a case had been closed without proper regard being paid to the need for public protection. I wish to mention only one case, that of Dr KI 01, because it illustrates the way in which conduct issues were often dealt with and demonstrates the potential unfairness to doctors which could arise through the operation of the procedures.

#### ***Dr KI 01***

22.152 Dr KI 01 was a surgeon. On one occasion, he attended for work whilst under the influence of alcohol. He began to conduct an operation and it was soon apparent to the nursing staff that he was having difficulty in using the necessary tools and equipment. The nursing staff called for help but, before this arrived, the doctor had fallen onto an instrument trolley. He was removed from the theatre. The hospital trust instituted disciplinary hearings. The doctor did not dispute the allegation that he had been under the influence of drink. It was accepted that he had been under considerable stress both at home and at work. He had taken drink on this one occasion to help him to cope with stress. It appears that he did not have a chronic drink problem. He was given a final written warning and was allowed to return to work under closely supervised arrangements.

22.153 The trust also reported the case to the GMC. The case was perceived by the GMC to be a health rather than a conduct case and was referred to Dr Mann. There was contact between the GMC and the Medical Director of the hospital trust. The Medical Director did not wish the GMC to become involved. He considered that the trust had the situation well under control. Dr Mann was impressed by the measures being taken locally. She formed the view that the situation was indeed under control and that there were no patient protection reasons to institute the health procedures. She decided to close the case. When she was asked at the Inquiry hearings why she had not referred the case to the medical screener for consideration of the conduct issues, Dr Mann could not remember. That is not surprising, as she deals with many cases, but it does underline the wisdom of recording reasons for decisions at the time they are taken. At the Inquiry hearings, there was some discussion of why she might have decided not to refer the case to the medical screener. One possibility was that the doctor had already received a final written warning in the context of his employment and Dr Mann might have thought that there was little point in him being given another warning by the PPC or PCC. In any event, the result of Dr Mann's decision was that the doctor avoided any disciplinary action by the GMC and escaped the possibility of a FTP record. If the case had been referred into the conduct procedures, the screener must surely have referred it to the PPC. Whether the PPC would

have referred the case to the PCC or have closed the case with a warning letter or a letter of advice, I cannot say.

### **Comment**

22.154 The point I want to make is that how a case is dealt with at the GMC is largely a matter of chance. If the case had been reported, not by the hospital trust, but by the patient who had found out what had happened, the case would almost certainly have been perceived initially as a conduct case. The medical screener might have consulted with Dr Mann as to whether a health issue arose. If Dr Mann had then arranged a medical examination or had consulted with the hospital trust, she would presumably have formed the view, as in fact she did, that there was no reason to institute health procedures. The case would have proceeded as a conduct issue and should, given its seriousness, have gone to the PPC. They might have issued a warning or they might have referred the case to the PCC. In that event, it seems likely that some sanction would have been imposed, probably a warning. The doctor would have had a FTP record. The potential for differences of treatment that depend not on the facts of the case, but upon matters of chance, is a cause for concern. Moreover, the recording of a warning, as a FTP history, may be important for patient protection. If a similar incident were to occur in future, it ought to be considered against the background of the first one.

### **Cases Handled within the Voluntary Procedures**

#### ***Dr JB 08***

22.155 The case of Dr JB 08 well illustrates the way in which, until the late 1990s, the health screeners were sometimes reluctant to refer cases to the HC notwithstanding repeated, serious breaches of undertakings. In the early 1980s, the doctor, a GP, was convicted of obtaining palfium tablets by deception and of unlawful possession of that drug. A large number of offences were taken into consideration by the court and it was apparent that the doctor had been taking these tablets himself over a substantial period of time. The case was considered by the PPC, which adjourned the case for 12 months on the first occasion, then adjourned for a further four months for medical reports. When received, the reports disclosed that the doctor was no longer dependent on palfium. The PPC then closed the case with a warning. I pause to observe that the facts of this case were similar to those of Shipman's case. Although the health procedures were already in operation at this time, Dr JB 08 was not referred into them; his case was dealt in the same way as Shipman's had been in 1976.

22.156 About three years later, the GMC received information from a PCO that suggested that the doctor might be suffering from mental illness and drug-related problems. It appears that he had recently given up practice. Nine months later, the GMC invited the doctor to undergo medical examination. Two reports were obtained from different medical examiners. They were delivered nearly a year apart in time. Both said that the doctor was unfit to practise owing to his abuse of alcohol and drugs. Just under two years after the PCO report, the doctor agreed to give undertakings. He was to place himself under supervision, to refrain from any form of medical practice and to abstain absolutely from

alcohol and self-medication. Six months later, the first report from the medical supervisor was discouraging. The doctor was drinking alcohol and had been issuing prescriptions for tranquillisers, ostensibly for his cohabitee, but the supervisor thought that the doctor was taking at least some of them himself. It was clear that there were multiple breaches of the undertakings. The doctor was advised that he was to remain under supervision and would not be referred to the HC at that stage. The medical supervisor's next report concluded that the doctor was complying with his undertakings but was unfit to practise on account of grossly impaired psychological functioning. Six months later, the supervisor reported that the doctor was drinking alcohol. Also, the doctor had been taking benzodiazepines prescribed by his GP as well as those prescribed by the medical supervisor; he had deceived his GP into prescribing them. Again, the health screener did not refer the case to the HC. There followed a further period of six years during which all save two of the supervisor's reports showed that the doctor was continuing to breach his undertakings. Eventually, nearly ten years after the doctor's problems had been reported by the PCO, the case was referred to the HC. The HC suspended him from practice and renewed the suspensions periodically until a few years ago, when it suspended him indefinitely.

### **Comment**

22.157 I accept that there was no evidence that this doctor breached his undertaking not to practise medicine. Thus, there was no evidence that he was a risk to patients. However, it does appear to me that the health screener was very tolerant of the doctor's repeated breaches. In my view, it would have been better if the doctor had been referred to the HC several years before he was. First, for his own sake, if he had been suspended, he would not have been able to prescribe drugs and one form of temptation would have been removed. Second, it seems to me that the GMC must not lose sight of its role as regulator. There is a danger that it will assume the role of treating doctor at one remove. Of course, as the Merrison Committee recognised, when recommending the institution of the health procedures, that the GMC must have humane ways of dealing with sick doctors. However, the GMC must find the right balance between the need for humanity and the proper role of a regulatory body. I can see that it may be difficult to do so.

### **Dr JE 02**

22.158 The case of Dr JE 02 illustrates many of the difficulties which can be experienced by the GMC in operating the voluntary health procedures and highlights some of the shortcomings of those procedures.

22.159 Dr JE 02's difficulties began in the early 1990s when he took to using controlled drugs, ostensibly to relieve stress, while working as a GP. He told his partners about this; they adjusted his workload and all appeared well. However, about two years later, one of his partners noticed that the doctor had been making a large number of entries in the practice's controlled drugs register. The doctor denied that he had relapsed into drug taking but the partners were sufficiently concerned to report him to the GMC.

22.160 The complaint was passed to the health screener. The caseworker's memorandum referred to the doctor's denial of drug misuse and to the absence of any direct evidence

of it. However, it appears that the health screener was suspicious and asked the doctor to submit to medical examination. The doctor agreed and the GMC obtained reports from two medical examiners. The first examiner found it difficult to reach a conclusion about recent drug abuse because of the lack of clear evidence. He observed, **'the evidence favouring the view that he was resorting to opiates again ... is quite compelling'**. The examiner noted that the doctor's usage of opiates, ostensibly for professional purposes, was ten times that of his partners. He concluded that Dr JE 02 probably had been abusing opiates and expressed the view that any misuse was not the product of, or associated with, any formal mental disorder. The examiner advised that the doctor was fit to practise subject to restrictions. The second examiner noted that there was little evidence of drug taking and that the urine tests were negative. He advised that the doctor was fit to practise without restrictions.

22.161 Thus, there was no agreement between the examiners as to whether Dr JE 02 had reverted to abusing opiates. When asked whether this issue should have been determined before it was decided how to proceed, Dr Mann expressed the view that she did not think that that would have achieved much. The evidence was uncertain, but the point was that there were real grounds for suspicion that the doctor had been abusing drugs. Therefore, the GMC would take the view that restrictions should be placed on the doctor for the protection of patients even though the facts had not been established. As I observed in the case of Dr JO 04, which I discussed in Chapter 20, there were occasions when, despite the fact that it had not been established that they were dependent upon, or addicted to, drugs, doctors were dealt with under the voluntary health procedures. I can see that such an approach might be justified on the grounds of patient protection, although it seems to me that it could cause problems in the future. Dr Mann was asked what, in a case such as this, would have happened if the doctor, after initially agreeing to voluntary undertakings, had refused to abide by them. She said that she thought that the giving of undertakings would be taken as a tacit acceptance that the doctor had a drug problem. However, if the case had been referred to the HC for breach of the doctor's undertakings, the HC would have had to decide whether there was a serious impairment of fitness to practise by reason of a physical or mental condition. It seems to me very doubtful that a 'tacit acceptance' would have been sufficient to establish such an impairment. Also, if, at some later stage, the doctor had again been reported to the GMC, it would have been open to him to say that it had never previously been established that he had abused drugs, or that he had suffered from a serious impairment of fitness to practise by reason of ill health.

22.162 In the event, the health screener asked Dr JE 02 to give voluntary undertakings, including undertakings (i) to refrain from all self-medication (ii) to comply fully with the controlled drugs regulations and (iii) not to engage in single-handed general practice. Noticeably absent was any restriction in relation to the doctor's prescribing rights. Dr Mann explained to the Inquiry that, at the time when these undertakings were devised, there was some reluctance to divulge information about undertakings to the doctor's colleagues. If a restriction had been placed on his prescribing rights, any doctor with whom he entered into partnership would have had to be told. She said that, at that time, to break a doctor's confidentiality in this regard was a heinous crime. Patient protection had assumed a higher profile in more recent times.

- 22.163 The doctor agreed to provide the undertakings and a medical supervisor was appointed and supplied his first report six months later. The supervisor referred to the fact that Dr JE 02 had recently started work in a new GP practice and that the new partner knew nothing of the doctor's previous health problems. In giving her evidence to the Inquiry, Dr Mann conceded that hiding the restrictions on the doctor's practice from those who needed to know was a 'foolish way' of conducting supervision. With regard to the current position, Dr Mann said that a doctor would be expected to inform his/her partners of voluntary undertakings that s/he had given.
- 22.164 Not long after giving his undertakings, the doctor moved to a different locality. This made contact with the medical supervisor difficult and the health screener expressed concern about the infrequency of reports. Eventually, the supervisor suggested the appointment of a different supervisor nearer to the doctor's place of work. Dr Mann made the point that too great a distance between medical supervisor and doctor lessened the chance of effective supervision. So, of course – as it seems to me – will frequent changes in supervisor. In this case, over the years, Dr JE 02 had no fewer than five supervisors; the changes occurred for various reasons. Dr Mann pointed out that this loss of continuity of care was a particular problem if the doctor was a locum and had no settled place of work.
- 22.165 Subsequently, the partner at Dr JE 02's new practice wrote to the GMC, stating that the doctor had been ordering large quantities of diamorphine and had admitted to self-administering diamorphine and pethidine. The partner considered Dr JE 02 to be unfit to practise. Thus, at this stage, the doctor was in breach of his undertakings. This was not even pointed out to him when the GMC wrote to him about his relapse. Dr Mann was unable to explain this, since she was not the health screener at the time. However, she said that, at that time, referral to the HC was not often considered. Since she had been a health screener, it had been her practice not to refer a doctor to the HC for a single breach of an undertaking although if there was evidence of repeated breaches or of real deceit, she would do so. She added that, once a case was in the health procedures, there was no mechanism for referring it into the conduct procedures. The only way in which a doctor could get back into the conduct procedures was if another allegation of misconduct or a conviction was reported.
- 22.166 In the light of the doctor's relapse, the health screener decided to appoint a specialist in drug addiction as medical supervisor. Dr Mann explained that this is now usual practice. The health screener also required the doctor to undertake to refrain from medical practice until permission to resume was given. The new supervisor's first report stated that Dr JE 02 had admitted to opiate misuse for about four years and to the misappropriation of drugs from the GP practices at which he had worked. However, he claimed that he was now drug-free. The supervisor advised that Dr JE 02 was fit to practise, provided that he remained drug-free; the supervisor recommended the imposition of restrictions, namely that the doctor should not work in general practice or prescribe Schedule 2 drugs. Dr JE 02 later gave undertakings to that effect.
- 22.167 The supervisor's next report was received over a year later. It reported that the doctor had received voluntary residential treatment for his drug problem. He was preparing for a new career in occupational health. A urine test had been positive for benzodiazepines but

negative for opiates. The taking of benzodiazepines constituted another breach of the doctor's undertakings, although possibly not a serious one. Five months later, the supervisor reported that the doctor had told him that the urine test had been positive because he had taken a single temazepam tablet to help him sleep the previous night. The supervisor wished to be released for geographical reasons.

- 22.168 Some months later, a new supervisor was appointed. He reported that the doctor was working in occupational medicine. There had been some suspicion that he had stolen a Cyclimorph tablet from a GP but this was denied. Supervision was to continue. The following year, the supervisor's report was most promising. There had been full co-operation and excellent progress. The doctor was still working in occupational health. By this time, Dr Mann had become a health screener. She agreed to continue supervision with an additional requirement that the GMC should be able to disclose the existence of practice restrictions to any enquirer. Dr Mann explained that she had been keen to introduce this undertaking into all cases being dealt with in the voluntary health procedures.
- 22.169 Over a year elapsed before the medical supervisor submitted his next report. Dr Mann commented that the practice of allowing 12 months to elapse between reports has now stopped and the normal frequency is six months. The supervisor reported that Dr JE 02 was still making excellent progress and was fully complying with his supervision and undertakings. Drug testing was again negative. The supervisor advised relaxing the undertakings to allow Dr JE 02 to undertake locum posts. Dr Mann agreed.
- 22.170 A year later, the report was, once more, wholly favourable. The supervisor advised that the doctor was fit to practise and recommended that supervision should cease. After noting that the doctor had been drug-free for over two years and that there had been no problems when his undertakings had been relaxed, Dr Mann decided that supervision could end.
- 22.171 Unfortunately, however, Dr JE 02 suffered a relapse almost immediately afterwards. The former supervisor notified the GMC that Dr JE 02 had been misusing opiates and had been dismissed from his employment. The supervisor had taken the doctor back into care for out-patient assessment and possible treatment. A hair analysis was positive for both pethidine and dihydrocodeine. As the doctor was not subject to undertakings at that time, he was not in breach of any conditions on his registration. Dr Mann said that she was disappointed to learn of the doctor's relapse. It appeared that he was able to resist substance misuse when external controls were in place but not otherwise. This was not uncommon, although the very short time interval in this case was unusual in Dr Mann's experience. She noted that the doctor had been prescribed pethidine following surgery the previous year and thought that this might have been a factor in his relapse.
- 22.172 Medical examinations were arranged. However, before the reports were available, further evidence came to light about the extent of the doctor's relapse. He had received a police caution for non-compliance with controlled drugs regulations. Also, the GMC received a copy of a report by the doctor's treating psychiatrist. This advised that the doctor was co-operating with treatment, but would need indefinite supervision. The doctor was fit to practise, but should be prevented from writing prescriptions. After receipt of the two medical examiners' reports, Dr Mann considered that the doctor was extremely vulnerable

to further relapse, his prescribing rights should be restricted and he should be placed under medical supervision for the remainder of his working life.

22.173 The doctor gave voluntary undertakings and was placed under supervision. The first report from the medical supervisor was satisfactory. The second showed such good progress that the supervisor recommended that conditions and supervision should cease, save for informal voluntary contact. Dr Mann did not agree to this, in the light of the previous history. The most recent report showed that progress had been maintained. Again, it was suggested that supervision should cease. Again, Dr Mann had directed that it must continue. She told the Inquiry that she was doubtful that it would ever be possible to cease supervision in this case.

### **Comment**

22.174 The case, which spans a period of ten years, illustrates some of the improvements that were made in the operation of the health procedures during that time. In the recent past, reports were obtained more frequently; more information was given to colleagues and employers and the health screeners were less tolerant than they had been of breaches of undertakings. There remained great emphasis on the rehabilitation of the doctor, but the protection of patients seemed to be given greater prominence.

22.175 The case also illustrates how the voluntary procedures can assist in keeping a doctor 'on the rails'. The procedures provide support, but are backed by the threat of suspension if the doctor lapses or fails to co-operate. However, Dr Mann expressed the view that local management would be preferable for doctors who require long-term supervision and support. I agree with her. I do not think that the provision of long-term support is wholly appropriate for a regulator. I think that the GMC should seek to divest itself of this function, which should be taken over by local PCOs or employers. A PCO can impose conditions on a doctor's practice and can provide a package of support and supervision. Provided that it is clear to the doctor that the package has the approval of the GMC and that failure to co-operate will result in a referral straight to the GMC's HC, the local procedures should not be any less effective than the GMC's voluntary procedures.

22.176 I realise, however, that if the doctor were peripatetic, the GMC would have to retain responsibility. In one of the cases examined by the Inquiry, that of Dr JK 03, the doctor was under supervision for nearly six years. During that time, he moved from hospital to hospital on three or four occasions. Continuity of supervision was difficult, even for the GMC, but it would have been almost impossible for a local NHS trust.

### **Dr JO 01**

22.177 The case of Dr JO 01 was of interest to the Inquiry as it illustrates the way in which a local organisation can work effectively in concert with the GMC. The doctor, a GP, had admitted to his partners that he had been abusing alcohol and drugs for a period of 10 to 15 years. The Chief Executive of the PCT attended a meeting at the doctor's practice and then investigated the extent of the problem by visiting practices at which the doctor had worked in the past. It appeared that the doctor had used prescriptions fraudulently to obtain his



supplies of drugs. Also, there had been concern about his performance in both his present and previous practices. There were reports that, at times, he was 'vague and disconnected', he fell asleep during consultations, he wrote medical reports that did not make sense, he occasionally prescribed inappropriately and he sometimes spoke inappropriately to patients. The PCT retained the services of a consultant who specialised in addiction and who was also an approved GMC medical supervisor. With his help, a set of undertakings was agreed with the doctor. The undertakings were very similar to those that the GMC would have imposed in its voluntary procedures and included regular medical supervision.

- 22.178 Despite having set up this package of measures, the PCT reported the matter to the GMC. The case was referred to the health screener with a memorandum which pointed out that the local measures appeared to be **'very robust'**. He or she suggested that, as the undertakings already in place were virtually identical to those which would be required by the GMC, it might not be necessary for the GMC to take action. However, the PCT became aware that the caseworker had expressed that view and they made plain that they wanted 'GMC back-up' as well. The screener agreed to accept the case into the voluntary health procedures despite the fact that it appeared that the local measures were appropriate. The GMC wrote to inform the doctor of this and advised him that he would be written to separately in respect of his apparently fraudulent use of prescriptions. In fact, no conduct proceedings ensued.
- 22.179 The GMC instructed two of its approved medical examiners to examine the doctor. They reached substantially the same conclusions as had the PCT's consultant and recommended very similar measures. The doctor agreed to undertakings drafted by the health screener. These continued in force and were likely to do so for a considerable time. It seems to me that the PCT had done a very good job in respect of this doctor. However, I can well understand why it wished to have the 'back-up' of the GMC. The threat of suspension by the HC must be a real incentive to compliance. It seems to me that, in a case where reports have been submitted by an employer or PCO and appear to have come from examiners who are independent of the doctor concerned, it would be reasonable for the GMC to rely on the reports and to formulate undertakings for the doctor to agree on the basis of their contents. What should, in my view, be avoided is reliance on reports commissioned by or on behalf of the doctor.

### **Dr JO 02**

- 22.180 The case of Dr JO 02 is of interest to the Inquiry because it involved allegations of quite serious misconduct coupled with concerns about the doctor's dependence on drugs. It shows that, even in recent years, the GMC tended to focus upon the rehabilitation of the doctor and to assume that any misconduct was merely part of the drug problem and that there would be no recurrence once the doctor had been cured of his/her dependence.
- 22.181 The GMC received a report that the doctor had been cautioned by the police for being in unlawful possession of heroin and cannabis. The amounts were not large. The doctor subsequently admitted himself to a private nursing home where he underwent 'detoxification'. Three months later, and before the GMC had taken any decision as to how

the report of the caution was to be handled, the GMC received a letter from the woman with whom the doctor had lived for about eight years. She alleged that the doctor had been abusing hard drugs for a considerable time and had often been to work, in various hospitals (which she named), while under the influence of cocaine, crack cocaine and heroin. She expressed surprise that the doctor's colleagues had not apparently noticed the signs of drug taking and wondered whether in fact they had noticed but had been unwilling to make any report. She also alleged that, although the doctor had recently undergone treatment, he had not given up drug taking; in fact, she said, he had taken crack cocaine on the very day he had left the nursing home. She said that he was now living with another doctor who was also under investigation by the GMC for similar addiction problems and for allegedly stealing drugs from hospitals. She also alleged that the doctor had been driving a motor car while under the influence of drugs and that she had witnessed many incidents of reckless or aggressive driving. She said that the doctor had been banned from driving for a time.

- 22.182 If these allegations were substantially true, it seems to me that the doctor might well have been guilty of SPM; he would have been attending work while under the influence of drugs. He would have been putting patients at risk. However, no one ever found out whether these allegations were true. The caseworker in the conduct section contacted Dr Mann to see whether the latter thought that the case should be referred into the health procedures. The caseworker was of the view that the caution alone might reach the SPM threshold. However, she thought that that misconduct might be considered as secondary to the doctor's dependency problem. Admission to the health procedures might be appropriate. Dr Mann thought that the case should be dealt with as a health matter. She considered that the letter from the doctor's former partner should be '**viewed with circumspection**'. In her experience, former wives and partners often made false allegations after the breakdown of the relationship. In the event, the letter from the former partner was completely ignored. No attempt was made to find out whether there was any truth in it, despite the fact that some of the allegations could easily have been checked. In fact, there might have been some truth in the former partner's tale because later, when medically examined, the doctor admitted that he had been abusing cocaine for seven years and heroin for one. Presumably, he had been working in various hospitals, as the former partner alleged, during that time.
- 22.183 In the event, the case was transferred into the voluntary health procedures. The doctor gave undertakings as required by Dr Mann and, at the time of the most recent report before she gave evidence, appeared to be doing well. He was about to begin vocational training with a view to becoming a GP. He remained under supervision. Dr Mann regarded his progress within the voluntary health procedures as indicative of success.
- 22.184 When Dr Mann was giving evidence before the Inquiry, Leading Counsel to the Inquiry asked her what steps had been taken by the GMC to find out whether any concerns had been expressed about the doctor and his performance at the hospitals at which he had worked. She replied that that was not a matter for her; her role had been to advise whether the health procedures were appropriate. I accept that that is so. She also said that medical examiners instructed by the GMC were expected to make enquiries about performance from people who had provided information to the GMC. She expressed surprise that no

concerns appeared to have been reported about this doctor. She agreed that, if a hospital was concerned about the behaviour or performance of a locum, it might just not employ him/her again in the future, rather than investigate itself or initiate a report to the GMC. It seems to me quite clear that the answer to Counsel's question was that no enquiries had been made about the doctor's performance. That is apparent from the GMC file and from the medical examiners' reports, which focus wholly on the doctor, his feelings about life and medical practice and his 'dysfunctional relationship' with his former partner. Dr Mann acknowledged that the GMC had perhaps not been as diligent as it might have been in collecting the relevant information.

### **Comment**

22.185 It is not for me to judge whether the former partner's letter was untruthful or even exaggerated. However, it does seem to me that the GMC failed to take any reasonable steps to investigate the quite serious allegations of misconduct, which clearly had implications for patient safety. I accept entirely that supervision within the health procedures provides a safeguard for patients. However, the GMC must not be surprised that the public does not have confidence in it if it sweeps aside allegations such as those made in this case without making any attempt to discover the truth.

### **Dr JO 07**

22.186 This case was of interest to the Inquiry because the circumstances were quite similar to those of Shipman's case in 1976. Dr JO 07's addiction to drugs and her criminal conduct came to light a few years ago when a pharmacist noticed that the doctor had presented two private prescriptions for diamorphine within the same week. The police were informed and it was found that the doctor had stolen diamorphine from the hospital where she worked and had also obtained the drug by deception by the fraudulent use of prescriptions. She was prosecuted, apparently in respect of drugs obtained over a period of about a month. Thus, her conduct was not unlike that of Shipman, although his was known to have persisted for much longer than did hers. Also, the doctor reported her forthcoming court appearance to the GMC quite voluntarily. The Magistrates imposed a community punishment order and directed that the doctor should pay compensation.

22.187 At the GMC, the case was referred to the IOC. In preparation for the hearing, the doctor's solicitors (instructed by her medical defence organisation) presented two psychiatric reports. These expressed the view that the doctor had begun using diamorphine while suffering from depression. There was no long history of substance abuse. The doctor was fit to practise, provided that she received psychiatric supervision and support. The IOC in effect accepted these reports and imposed conditions on the doctor's registration for a period of 18 months. These comprised a requirement to submit to psychiatric supervision, to work only in supervised posts approved by her postgraduate dean and to notify all potential employers of the conditions under which she was practising. Six months later, the IOC reviewed the case and continued the restrictions. Soon afterwards, the doctor was advised that her case had been referred to the PPC. Her solicitors wrote to the GMC, asking that she should be dealt with through the health procedures and, when the case

came up for consideration by the PPC, it adjourned it for consideration under the voluntary health procedures. A month later, the doctor was advised that her case would be dealt with under the voluntary health procedures. She had not been and, so far as I can see, never was examined by a medical examiner instructed by the GMC. She was invited to give undertakings to accept medical supervision, to confine her practice to posts approved by her postgraduate dean and not to prescribe drugs listed in Schedules 1 to 3 of the Misuse of Drugs Regulations 2001. The doctor gave the undertakings, the IOC order was revoked and, presumably, the conduct proceedings were closed. The medical supervisor's first report, which was provided within three months, was wholly favourable. It was then just over a year since the doctor's conviction. The second report, received six months later, suggested that the doctor could now practise without restriction. However, the health screener decided to maintain supervision for a further six months to monitor continued progress. That was the position at the time when the Inquiry obtained the file in 2003. It was clear that, if the next report were satisfactory, the doctor would be allowed to practise without restriction. That would be just over two years after her conviction.

### **Comment**

22.188 This case is so similar to that of Shipman that it appears likely that the way in which it was handled is indicative of the way in which Shipman's would have been treated if it had been reported in the recent past. The health procedures appear to have operated well. I note, however, that the PPC referred this case into the health procedures on the basis of reports submitted by the doctor's medical defence organisation. Although this was permissible under the Rules, it was not an ideal way of proceeding. It will usually be preferable to obtain reports from the GMC's own approved examiners, in order to ensure independence, rather than to accept reports commissioned by or on behalf of the doctor.

## **The Future of the Health Procedures**

### **The General Medical Council's Internal Arrangements**

22.189 At the time when she gave evidence to the Inquiry, Dr Mann was expecting to cease acting as a health screener within a few months. She said that she, her fellow health screener Dr Wilson and other colleagues in the GMC were concerned that the expertise that she and Dr Wilson had acquired could be lost. In the past, there had been continuity of health screeners, with the more junior screener learning from the senior screener and then taking over when the senior screener left. At the time Dr Mann gave evidence, the GMC was still attempting to recruit a consultant psychiatrist as a case examiner who would assume responsibility for health cases. However, it had not been successful in doing so and Dr Mann was concerned that there would not be an adequate period of overlap between the existing health screeners and the case examiner who, as she expected at that time, was to assume their role. Another problem was that many of the caseworkers who had experience of the health procedures had left in anticipation of a removal of the Health Section to the GMC's new Manchester office. Dr Mann said that she and Dr Wilson were 'very keen' to make sure that the procedures which seemed to be 'running more smoothly now than they were some years ago' were not 'cast back'.

22.190 I share Dr Mann's concerns. In my view, she and her colleague have reason to be proud of the work they have done in the health procedures in recent years. I think that it would be a tragedy if the expertise which Dr Mann, Dr Wilson and their team of staff built up were to be lost. However, I have other concerns about the future. It now appears that the role of the health screener is not to be transferred to a case examiner at all. It appears that that role will, to a large extent, be assumed by members of the GMC staff. Such staff members would not, as I understand it, be medically qualified. They would certainly not be psychiatrists of good standing and long experience as the health screeners have generally been.

## Conclusions

22.191 As I have indicated, in my view, the GMC has cause to be proud of the way in which the health procedures have operated in recent years. One of the reasons that they are as good as they are is that, in the late 1990s, the GMC invited an independent evaluation of the procedures as they were then operating and improved their procedures in the light of that evaluation. This evaluation, and the GMC's response to it – for which, in my view, it is to be congratulated – demonstrates the value of an independent professional view. Careful examination of 40 sample cases demonstrated the problems that beset the health procedures at that time and allowed them to be corrected.

22.192 Another reason for the success of the procedures has been the expertise of the health screeners. They and their staff have been a small but stable group which has been able to develop consistency of practice and decision-making. I shall return in Chapter 25 to consider the way in which the health procedures will operate in future. However, I must say now that, if the expertise and experience of the team which was in place in late 2003 has been lost, it will take a long time to replace.

22.193 Having said that, it seems to me that there were a number of remaining weaknesses within the health procedures as operated up to 2004. First, the practice of referring a case of alleged drug abuse into the voluntary health procedures without the facts of the matter having been established was not satisfactory. It might have been convenient and it might have appeared to provide protection for patients in a case in which there was a risk that the PCC might find that the doctor was not guilty of the misconduct alleged. However, it led to a fudging of the issues. Establishing the true facts was necessary for several reasons. If the doctor entered voluntary health procedures without the facts having been established, it might have been impossible for the HC to act if the doctor breached his/her undertakings or if, following a relaxation of the conditions, the doctor then suffered a relapse. I shall say more about the need to establish a factual basis before dealing with a doctor within the voluntary health procedures in Chapter 23.

22.194 There has until now been very little investigation of the extent to which a health problem of whatever kind has affected the doctor's clinical practice and might do so in the future. Such information is vital if the conditions imposed on the doctor are to be accurately tailored to the risks they have to cover. Investigations of this kind might involve quite a lot of delving, especially if the doctor is a locum or has moved from post to post. At the Inquiry seminars, there was discussion about the provision of a central database which would,

when it had been in operation for a few years, provide useful information about doctors' *curricula vitae*. Such a database would be very useful for enquiries of this nature. In the past, such enquiries as have been made have been left to medical examiners. It does not seem to me to be an appropriate function for them. They may not consider it to be appropriate to delve into the doctor's past. In any event, they are likely to have limited resources.

- 22.195 There has been a lack of standards and criteria for deciding whether the doctor is suffering from a serious impairment of fitness to practise by reason of a physical or mental condition. Since such decisions have been taken mainly by one or other of the two very experienced health screeners, there does not appear to have been any great problem of inconsistency in the past. However, members of the HC would not have the same degree of experience as the health screeners. In any event, achieving consistency is not the only reason why there should be standards and criteria. They are also required in order to provide transparency. It ought to be possible to test the decision against a set of objective criteria so that its reasonableness can be demonstrated. If, under the new FTP procedures, decisions about whether fitness to practise is impaired by reason of adverse health are likely to be taken by a large number of panellists, case examiners and staff members, clear criteria will be urgently required.
- 22.196 It seems to me that, in recent years, the arrangements for medical supervision were satisfactory. However, the arrangements for professional supervision were less good. For a doctor who is allowed to practise subject to conditions, a professional supervisor is essential. He or she should be in frequent contact with the doctor concerned and should also have direct contact with the GMC decision-maker. In the past, contact has been indirect, through the medical supervisor. I think that the GMC decision-maker needs to have a good 'handle' on how the doctor is coping at work and how colleagues feel about working with him/her. Professional supervisors should have their role explained to them, as medical supervisors do.
- 22.197 The inability under the old procedures to consider performance at the same time as health problems was a difficulty but that should now be resolved under the new procedures. There will be some cases in which an assessment of both performance and health will be required before any decision is taken. The resource implications of such assessments are significant. At the moment, performance assessments are slow and expensive. There is a need for a quicker and less expensive assessment process. I wondered whether something along the lines of the NCAA assessment might be sufficient, at least to establish whether a problem exists. I can see that something more thorough might be required if evidence is to be put before a FTP panel to back up an allegation that there is sufficient impairment of fitness to practise to justify action on registration. I also think that a simple form of assessment should be developed for use when a doctor is about to return to practice after a period of suspension or restricted practice. The GMC has facilities for administering Professional and Linguistic Assessment Board (PLAB) tests. I wonder whether those facilities could be used for assessments of this kind.
- 22.198 For many years, the information provided to PCTs and to the partners of GPs involved with the health procedures was very limited. In recent years, the position has improved to some

extent in that at least they are now told that the GMC is involved. However, the amount of information is still quite meagre. It seems to me that, if a doctor is to be allowed to practice notwithstanding that s/he has a problem (such as a drink or drug problem), it should be on condition that the doctor's partners and PCT are given all the essential information; at the very least they must be told the diagnosis, the prognosis and the recommendations of the medical examiner. Partners are responsible for the practice's patients and PCTs have clinical governance responsibility for the quality of care provided by the practice. It is not satisfactory for them to be dependent upon what information the doctor him/herself is prepared to divulge or what the medical supervisor is prepared to tell them.

22.199 For the future, the good management of doctors under supervision in the health procedures is essential. In the recent past, the procedures worked well, with health screeners and staff having their own roles. The system of referring doctors to the HC if they breached their undertakings was working well. I am concerned that the changed arrangements under the new procedures will create a risk that the standards established in the last few years might not be maintained. I urge the GMC to think again about the decision to use staff, rather than case examiners, for much of the management of doctors under health supervision.

22.200 One problem at least should be resolved as soon as the new procedures are in operation. Under the old procedures, when a doctor was convicted of criminal offences associated with a health problem, the GMC did not in general mark the serious nature of the conviction in the context of medical practice. Instead it dealt with such cases on a purely rehabilitative basis, by giving the doctor the benefit of the chance to rehabilitate under the voluntary health procedures. Convictions for drug abuse, for example, could have been sent to the PCC but, were in fact invariably referred into the voluntary health procedures. Thus, the public did not know what the GMC was doing about the doctor. This was not so much a weakness of the health procedures as a weakness in the way the GMC chose to deal with a certain type of case. Under the new procedures, most conviction cases should be referred to a FTP panel. There will be a public hearing and, if the doctor later has conditions imposed on his/her registration or is referred into the voluntary health procedures, at least the public will know that that has been done.