FAMILY HEALTH SERVICES APPEAL AUTHORITY

Case No 13378

Panel Members
Mr Christopher Limb - Chairman
Dr Raj Rathi – Professional Member
Mr Mark Rayner – Lay Member

BETWEEN:

DERWENTSIDE PRIMARY CARE TRUST
(now County Durham Primary Care Trust)

Applicant

and

DR EDWARD J NOWICKI
GMC reg no 4200079

Respondent

DECISION

1. This is our Decision upon the application of the Primary Care Trust for an Order of National Disqualification. We sat in Newcastle on 3rd January 2007. Such application is made following the Primary Care Trust Decision in July 2006 to remove Dr Nowicki from the Medical Performers List. Such Decision was made following a hearing on 18th July 2006 and notified by letter of 19th July 2006. There has been no appeal against the Decision of removal.

2. For the avoidance of confusion, it is noted that since the time of Decision in July 2006 there has been reorganisation of the Primary Care Trusts and County Durham Primary Care Trust now comprises the area of five previous Trusts including that of Derwentside Primary Care Trust.

3. The basis of the PCT Decision to remove Dr Nowicki from the Performers List comprised three elements:
   (a) Attempting to obtain Dihydrocodeine tablets (Dihydrocodeine being a Class B controlled drug under the Misuse of Drugs Act 1971) using a false identity and a prescription he had retained from a practice in Blyth at which he had previously worked as a Locum. Such occurred on 30th May 2006 and Dr Nowicki accepted a Formal Caution from the police following arrest. Such was relied upon by the PCT as amounting to a "fraud" pursuant to paragraph 10(4)(b) of the National Health Service (Performers List) Regulations 2004 ("the Regulations").

   (b) The selfsame facts of attempted obtaining of Dihydrocodeine by deception amounted to a failure to comply with the conditions pursuant to which Dr Nowicki was included on the List, pursuant to paragraph 8(2) of the Regulations.

   (c) Removal of medication previously prescribed to patients and subsequent use of such medication (Dihydrocodeine) for his own use were also considered to be a serious breach of the doctor/patient relationship and rendered continued inclusion in the Performers List prejudicial to the efficiency of services pursuant to paragraph 10(4)(a) of the Regulations.

LEGAL FRAMEWORK/PRINCIPLES

4. Section 49N of the National Health Service Act 1977 as amended gives the power to make an Order of National Disqualification, namely an Order disqualifying the practitioner from being upon the Performers List of any PCT. The FHSAA does by sub-section 4 have such power upon application of a PCT who have removed a practitioner from their Performers List. There is no statutory guidance as to the principles to be applied in such context. In our opinion it is proper to consider national disqualification in those cases where the findings against the practitioner are serious and are not by their nature essentially local in the sense of being objectively unlikely to have arisen had the practitioner been in a different area of the country. We find the "Advice for Primary Trusts on List Management" published by the Department of Health in August 2004 supportive of such approach particularly in paragraph 40.4 : "Unless the grounds for a removal or refusal to admit were essentially local, it would be normal to give serious consideration to such application (for national disqualification)".

FACTS/EVIDENCE/SUBMISSIONS

5. Although on the face of the papers it appears there may have been dispute as to some aspects of the facts it was clarified at the beginning of the hearing on 3rd January 2007 that those facts relied upon by the PCT were not in dispute. Such facts were:
    (a) the fraudulent attempted obtaining of Dihydrocodeine on a false prescription on 30th May 2006 by Dr Nowicki;

    (b) the personal use of Dihydrocodeine by Dr Nowicki which he had removed from patients to whom such Dihydrocodeine had been prescribed;

    (c) the action referred to in (b) took place over a period of about seven to eight weeks from an unspecified number of patients. The PCT did not base their application upon a specific number of patients but relied upon the nature of such activity. Dr Nowicki in answer to questions from Dr Rathi in the course of the hearing indicated that the use over such period was in the range of 15 to 40 tablets per day (the amount increasing over time as tolerance increased).

6. The foregoing facts were against the background of Dr Nowicki having become dependent upon Dihydrocodeine in 1999 and as a result and pursuant to the General Medical Council health procedures being subject to undertakings in relation to his GMC registration and subject to conditions upon his inclusion in the PCT Performers List. As current at the date of events in 2006 those conditions were as set out in a letter of 15th July 2004. Those conditions are numerous and lengthy and we do not set them out in full. Amongst those conditions was the requirement for Dr Nowicki to be under the medical supervision of Dr Gilvanny, to refrain from self medication, to comply with any arrangements made by the medical supervisor for testing of (inter alia) urine for recent and long term ingestion of drugs and (in effect) to follow the advice of the medical adviser in relation to professional commitments and work.

7. Both in a written statement and in oral evidence before us, Dr Nowicki expanded a little upon such history and indicated in relation to the stresses which existed at the time of Dihydrocodeine abuse that in 1999 such stresses related to his then new job in a deprived area and in which promises of funding and other significant resources had proved to be unfulfilled and the Practice which he entered was found by him to be subject to medical mismanagement and financial irregularities. In 2006 the stresses arose from his work in attempting to reduce over-prescription of drugs (and in particular opiates and more particularly Dihydrocodeine). The levels of prescriptions by the Practice by which he was employed were significantly higher

than the average for the area and in excess of good practice. Dr Nowicki indicated that he initially undertook medication reviews and included removal of drugs already prescribed in such process without express intention to use those drugs himself but thereafter started to use such removed drugs for his own purposes. It appears that by such time the previous frequency of urine testing had diminished or had ceased and that had the events leading up to and including 30th May 2006 not occurred there may well have been recommendation from Dr Gilvanny that there was no longer need for supervision or restrictions upon practice.

8. Dr Nowicki emphasised that since May 2006 he had received very considerable support well above that available previously and that he had as a result gained far greater insight into his addiction and problems. He has attended both an initial intensive course with "Acorns Outreach" (a group providing treatment for alcohol and drug dependents by analogy with the Twelve Step Programme of Alcoholics Anonymous) and thereafter attended weekly group meetings of their Support Group for healthcare professionals. He similarly attends the monthly regional meeting of the Doctors and Dentists Group. We have had the benefit of a letter dated 2nd December 2006 from Acorns Outreach indicating their view that he has cooperated fully with the programme and indicating the view that he should be allowed to return to full practice and indeed will be able to bring a particular benefit to practice because of his greater understanding of addiction. We have also received letters from Dr Featherstone and Dr Richardson who have been variously involved with Dr Nowicki with the Support Groups to which we have already made reference (as well as "GP Choices" which is a branch of the Occupational Health Service in the area). They both indicate that he has cooperated fully with treatment and (in effect) there is a good prospect of his fully recovering so as to be able to practice with benefit to his patients and that there is no need for a national disqualification by this Tribunal in addition to such restrictions and safeguards as may be determined by the General Medical Council.

9. It should also be noted that in August 2006 the Interim Orders Panel of the General Medical Council imposed conditions upon his registration. Such are set out in their letter to the Primary Care Trust of 18th August 2006 and in particular include conditions that his medical practice must be subject to supervision and that he must not prescribe any drugs. The latter condition effectively precludes him from general practice. Such conditions are imposed for a period of eighteen months albeit subject to review after six months, namely in February 2007. Such Orders are made upon the basis of being an Interim Order without any finding in relation to Dr Nowicki by the GMC.

10. As confirmed by Dr Nowicki in answer to questions on behalf of the PCT he has not been able to produce a report as to his condition or prognosis from either Dr Gilvanny or Dr Hearn (who has taken over the treating role of Dr Gilvanny) nor from his personal GP nor from his Mentor, Dr Astley.

11. The PCT have been represented before us by Mr McKernan, Solicitor. Dr Nowicki has been assisted by Mr Carter of the British Medical Association, who is not legally qualified. We have heard submissions in part from Dr Nowicki directly and in part from Mr Carter on his behalf.

12. Mr McKernan referred to paragraph 40 of the Department of Health guidance to which we have already referred and to broad principles from previous decisions in the FHSAA to the effect that national disqualification is to be considered by reference both to the effects of national disqualification upon Dr Nowicki and the safety and efficiency of the service to be provided to patients and whether in such a context national disqualification is a proportionate and reasonable step to take. He laid emphasis upon the fact that there were no formal medical reports upon Dr Nowicki and in particular none from those who had had longstanding practical involvement in his treatment or supervision. He submitted that the FHSAA was not in any way bound by the decisions of the GMC but had to exercise its own judgment. He submitted overall that it was fundamental to consider whether Dr Nowicki could be

considered suitable to provide primary care in the context of both his own safety and patient safety.

13. Mr Carter in his closing submissions suggested that it was necessary to consider the interests of patients of employers and of Dr Nowicki himself. He submitted that the steps already taken by the GMC effectively removed any risk Dr Nowicki might pose to patients or others and that the situation was satisfactorily managed by the GMC regime and the current conditions. He submitted that so far as Dr Nowicki's interests were concerned, national disqualification could be of potentially great damage and seriously harm the prospects of eventual return to practice. He emphasised the greater insight Dr Nowicki now had in view of the assistance received from sources such as Acorns Outreach. Overall he suggested that there would not be any inappropriate risk if national disqualification was not ordered.

CONCLUSION

14. We are satisfied that the agreed factual background of the removal of Dr Nowicki from the Performers List of the Applicant rendered him unsuitable to be on their List and that the selfsame reasons justifying his removal from the Derwentside List are equally relevant to any other List.

15. We are satisfied that the events on and leading up to 30th May 2006 are serious in nature and the more serious because they take place over a period of weeks and against a background of a previous addiction to Dihydrocodeine in 1999.

16. The FHSAA rightly takes note of and gives respect to the decisions of the General Medical Council. Its decisions and their effects are very properly one of the considerations in this case and all cases in which a practitioner is subject to processes in both Tribunals. The FHSAA has its own obligation to consider the issue of national disqualification and cannot simply rely upon the prospect of the GMC taking all necessary actions. It is to be noted that in the present case there has been no finding by the GMC and the current order is by the Interim Orders Panel. It is also to be noted that the roles of the FHSAA and the GMC are not entirely comparable and that in particular this Tribunal does not undertake a role as a disciplinary body with safeguards for the practitioner relevant to such a role. This Tribunal is concerned principally with the interests of patients and the safety and efficiency of the service provided to patients.

17. We remind ourselves of the notable effect of an Order for National Disqualification upon Dr Nowicki and the practical effect of it preventing him pursuing his career as a general practitioner within the NHS for a minimum of two years. We weigh such consideration against the risk to patients and the efficiency of the service provided if an Order for National Disqualification is not made in the context of a general practitioner unlawfully taking prescribed drugs and in particular drugs originally prescribed for his own patients. We consider an Order for National Disqualification reasonable, necessary and proportionate. We order National Disqualification from inclusion in all Lists prepared by all Primary Care Trusts and all Health Authorities including but not limited to those referred to in Section 49N(1) of the National Health Service Act 1977 as amended.

18. This is not a case in which we consider that the nature of the conduct of Dr Nowicki is such that we should make an Order under Regulation 19 that an application for review cannot be made for five years.

19. In the context of Dr Nowicki not having formal legal representation we draw to his attention that pursuant to Regulation 18A a request for review may (dependent upon evidence and merits) be made after two years beginning with the date on which this National Disqualification is imposed.

20. Any party to these proceedings can appeal this Decision under Section 11 of the Tribunals Inquiries Act 1992 by lodging Notice of Appeal at the Royal Courts of Justice, the Strand, London WC2A 2LL within 28 days from receipt of this Decision.

Dated the 4th day of January 2007

Christopher Limb – Chairman
Dr Raj Rathi – Professional Member
Mr Mark Rayner – Lay Member