FAMILY HEALTH SERVICES APPEAL AUTHORITY
SITTING AT FHSAA, HARROGATE

Case No: 13478

BETWEEN:

DR JOHN GRAY
GMC Reg No: 2277073

Appellant

and

OLDHAM PRIMARY CARE TRUST

Respondent

DECISION

Panel Members:
Mr Christopher Limb – Chairman
Dr E Walsh-Heggie– Professional Member
Mr C Barnes– Lay Member

Introduction

1. We sat on three days to consider this matter. The case started on 26th February 2007 and continued on 2nd and 3rd May 2007. The evidence was completed on 2nd May 2007. On 3rd May we had the assistance of written submissions from both parties as well as their oral submissions. We were greatly assisted throughout by Counsel, Mr Colin representing Dr Gray and Mr Peacock representing the PCT.

2. Dr Gray has been qualified since 1975 and has been working at the Crofton Surgery in Oldham for the majority of time since then. Until the Decision which forms the basis of this Appeal he was on the Medical Performers List of the Respondent.

3. The Respondent first investigated matters relevant to this hearing at the beginning of May 2006. At a time when Dr Gray was away on holiday the PCT was alerted by a local pharmacist of the possible use of prescriptions which had been pre-signed by Dr Gray but were otherwise blank and used in his absence by non-qualified staff and (as became apparent shortly thereafter) in particular by a Nurse Practitioner at Dr Gray's practice. Dr Richard Orr was appointed as investigating officer. He is Associate Director of Medicine with the Respondent PCT and also a practising general practitioner.

4. After Dr Gray's return from holiday, after some initial investigations had taken place and interviews held with some of the staff at the Crofton Surgery, and after Dr Gray had been interviewed, Dr Orr wrote a report dated 16th May 2006 for the assistance of the Performance Panel of the Respondent PCT which on that date considered suspension of Dr Gray from the Performers List. Amongst the evidence presented in such report was that approximately 2,000 blank prescriptions pre-signed by Dr Gray had been found, that such pre-signed prescriptions were for use by the Nurse Practitioner, and that such practise had been ongoing for about two years. Dr Gray accepted that such arrangement existed. There is reference in the report to the Nurse Practitioner acting "like another GP". There was evidence of problems in the practice (in which Dr Gray was the sole doctor) relating to the premises being inadequate in terms of space and access, in relation to the over-large List size, and in

relation to failure to recruit other general practitioners. There was also evidence of pre-signed sick notes albeit no indication of the detail in such regard. Dr Orr summarised the concerns as "1. Presentation to local pharmacies of prescriptions signed by Dr Gray while he was out of the country. 2. The discovery of a very large number of signed blank prescriptions. 3. The possible completion and issuing of pre-signed prescriptions (by) non-qualified clinicians. 4. The provision of inadequate medical cover for the practice population, especially in regard to emergency home visit requests. 5. The inappropriate delegation of medical duties to an unqualified medical practitioner". Dr Orr indicated that the Panel would need to consider the risk to patients as a result of the foregoing matters and in particular whether there was a continuing risk, conditions for removal or suspension, possible breaches of contract between Dr Gray and the PCT, and possible referral to the General Medical Council. His final sentence of the report recommended contingent removal conditions.

5. The Performance Panel of the Respondent PCT considered the matter and heard from both Dr Orr and from Dr Gray. Its decision was to suspend Dr Gray pursuant to Regulation 13(1)(a) of the NHS (Performers Lists) Regulations 2004 ("the Regulations") for a period of six months. Such was notified to Dr Gray by letter of 19th May 2006.

6. The PCT thereafter carried out further investigations and Dr Orr prepared a further written report. A Panel hearing was then held on 2nd November 2006. In his report, Dr Orr's main recommendation was removal but he also provided draft suggested conditions if the Panel considered contingent removal appropriate. Dr Gray attended the hearing together with a representative from his medical defence organisation. The Decision of the Panel was to remove Dr Gray and he was notified of such Decision by letter of 8th November 2006. Such removal was by reference to Regulation 10(4)(a), namely "an efficiency case". Under cover of letter of 27th November 2006, Dr Gray exercised his right of appeal. This is our Decision upon such appeal. Pending the appeal, Dr Gray has remained suspended from practice pursuant to a further Decision of the PCT on 15th November pursuant to Regulation 13(1)(7) until disposal of this Appeal.

Legal Framework

7. The Appeal is brought pursuant to Section 49M of the National Health Service Act 1977 as amended by the Health and Social Care Act 2001 and Regulation 15. The FHSAA can make any Decision which the PCT could have made and the hearing is in the nature of a re-hearing. The centrally relevant Regulations are as follows. By Regulation 10(3) and (4) the PCT may remove a performer from the List if "(a) his continued inclusion in its Performers List would be prejudicial to the efficiency of the services which those included in the relevant Performers List perform ("an efficiency case")". Pursuant to Regulation 11(5) a PCT must take into account in an efficiency case those matters set out in Regulation 11(6). Those matters are:
    (a) the nature of the incident which is prejudicial to the efficiency of the services;
    (b) the length of time since the last incident and since conclusion of any investigation;
    (c) any action by any licensing, regulatory or other body, the police or the Courts;
    (d) the nature of the incident and whether there is a likely risk to patients;
    (e) whether the performer has ever failed to comply with a request to undertake an assessment by the NCAA;
    (f) whether the performer has previously failed to supply information, make a declaration or comply with an undertaking;
    (g) the circumstances of any refusal of admittance, conditional inclusion, or removal or contingent removal or suspension from any PCT List or its equivalent;
    (h) (not relevant).

    By Regulation 11(7) the PCT in taking a Decision under Regulation 10 must take account of the overall effect of any relevant incidents and offences relating to the performer of which it is aware.

8. In an efficiency case, Regulation 12 provides that instead of removal the PCT may decide to remove a practitioner contingently and if it so decides must impose such conditions with a view to removing any prejudice to the efficiency of the services in question.

9. In paragraph 7.4 of The Department of Health guidance document "Primary Medical Performers Lists - Delivering Quality in Primary Care" (August 2004) indicates that efficiency cases concern issues of competence and quality of performance : "They may relate to everyday work, inadequate capability, poor clinical performance, bad practice, repeated wasteful use of resources that local mechanisms have been unable to address, or actions or activities that have added significantly to the burdens of others in the NHS (including other doctors)".

10. As indicated below there is no dispute as to the facts upon which the PCT rely. However in principle the burden of proving any fact relied upon to justify removal is upon the PCT and must be demonstrated on balance of probabilities.

Facts/Evidence

11. We have heard oral evidence as follows. The PCT called Dr Orr (to whom we have already referred) and also Shauna Dixon, Executive Director of Clinical Leadership at the Respondent PCT and Chair of the Panel on 2nd November 2006. In addition to their oral evidence we had formal written statements from both Dr Orr and Mrs Dixon. The Appellant gave oral evidence and we also had his formal written statement. In addition the Appellant called oral evidence from his two current partners, Drs Waseem and Kamal, and two patients, Canon Dr Hilditch and Mrs Lesley Fudge. In respect of the latter four we had relatively short informal statements or letters from them in addition to their oral evidence and, as is plain from Mr Colins' written submissions, they are relied upon together with the written statements/letters of various other patients to show "the high regard in which the Appellant is held by his patients as a doctor and as a person" and (so far as concerns Dr Waseem and Dr Kamal) that his partners value him and are themselves young and dynamic in their approach to the future of the Practice at Crofton Surgery. We were also assisted by substantial written evidence in bundles provided by both parties.

12. It is to be noted that the Appellant's case is to the effect that there should be contingent removal and there is no dispute that there is a proper finding of inefficiency within the meaning of the Regulations. It was expressly confirmed at the beginning of the hearing (and such confirmation is repeated in the written closing submissions) that there are no factual issues with the findings of the report of Dr Orr presented to and considered at the hearing of 2nd November 2006.

13. The main findings of Dr Orr as set out in his report were as follows:

    1. <u>Use of blank pre-signed computer prescriptions</u>

    - Those NHS prescriptions, with Dr. Gray's signature had been issued to patients and presented to local pharmacists and dated during a period when he was known to be out of the country.
    - That Dr. Gray had pre-signed a large number of prescriptions (approx 2000).
    - That pre-signed blank prescriptions were completed and issued to patients by Mrs. G. Cottam, a nurse practitioner employed by Dr. Gray.

- That Mrs. Cottam was not a registered supplementary nurse prescriber at the material time. A supplementary prescriber is a person whose name is registered in the nursing and/or midwifery register against whose name is recorded in the relevant register an annotation specifying that he or she is qualified to order drugs, medicines and appliances as a supplementary prescriber.
- That the practice of using pre-signed blank prescriptions had been in place at the practice for a number of years.
- Blank pre-signed prescriptions had been placed in the reception printers and routinely issued by staff for repeat prescriptions. The current practice manager had stopped that practice approximately one year ago.
- Under the terms of the GMS contract between Dr Gray and PCT Dr Gray agreed in clause 273 that "in issuing any non electronic prescription form or non electronic repeatable prescription the prescriber shall sign the prescription form or repeatable prescription in ink with his initials, or forenames, and surname in his own handwriting and not by means of a stamp, and shall so sign only after particulars of the order have been inserted in the Prescription form or repeatable prescription."

2. Lack of medical cover for routine and emergency cover

- That during his absence on holiday, locum GPs were only engaged for 2-hour sessions twice a day with no medical cover in between.
- That Dr. Gray allowed a nurse practitioner, Mrs. Cottam, to provide medical cover in his absence.
- That Dr. Gray encouraged and allowed Mrs. Cottam to undertake responsibilities that are not compatible with her training and qualifications.
- That Dr. Gray was aware that he was not providing adequate medical cover to his patients for a period of at least 2 years prior to May 2006 and employed and allowed Mrs. Cottam to act in the role of a doctor to provide cover for him.

3. List size

- That Dr. Gray developed a number of coping strategies for managing a list size of 5000 patients. This included operating an open morning surgery where a large number of patients would be seen over a short period of time by either the nurse practitioner or by Dr Gray.

4. Medicine management and prescribing

- That Dr. Gray did not follow standard [insert GMC/PCT/NICE etc] protocols for repeat prescribing and did not have systems in place at the practice to monitor and manage repeat prescriptions.

5. Record keeping

- That Dr. Gray did not ensure that adequate patient consultation records were made by Mrs Cottam during the open morning surgery.

6. Use of blank pre-signed sick notes

- That Dr. Gray permitted Mrs. Cottam the nurse practitioner to complete and issue blank Med 3 sick notes that had previously been signed by him.

7. Staff training, appraisal and supervision

- That Dr. Gray failed to ensure that staff, in particular the nurse practitioner had adequate appraisal and clinical supervision.

8. Good Medical practice and the GMC standards

- That Dr. Gray has failed to meet the following GMC standards as set out in the GMC publication -Duties and Responsibilities of Doctors.

14. Although Dr Orr's primary recommendation was for removal, he also set out possible conditions if contingent removal was accepted. Such in summary were:
    1. Dr Gray to inform the PCT of arrangements for the provision of medical cover in advance of his absence from the Practice;
    2. Dr Gray must review his compliance with his contractual obligations under the GMC contract;
    3. Dr Gray must close his Patient List and agree a recovery plan to reduce the List size or recruit additional medical staff;
    4. Dr Gray must undertake not to pre-sign blank prescription forms or sick note certification forms and comply with his professional and regulatory obligations in relation to such matters;
    5. Dr Gray must review the systems and protocols for the safe handling of repeat and acute prescriptions;
    6. Dr Gray must work with the PCT Medicine Management Team in relation to prescribing policies;
    7. Dr Gray must review and update staff job descriptions and contracts;
    8. Dr Gray must undertake review of staff training needs and produce a plan for training;
    9. Dr Gray must undertake appraisal of all clinical staff;
    10. Dr Gray must ensure all clinical staff have clinical supervision.

15. The aspects of Dr Orr's oral evidence to which reference has been made in particular include the following (as highlighted in the Appellant's written Closing Submissions). Whilst Dr Orr had commented that Dr Gray's suggested conditions put forward at the meeting in May 2006 were very disappointing, he conceded in cross-examination that Dr Gray had had less than 24 hours to consider the matter (and Dr Gray gave evidence that the handwritten single piece of paper had in any event been prepared by him solely as a "crib sheet" and had been produced at the hearing because the

Panel members had asked to see the document he was referring to). There had been similar comment as to the lack of any substantial response by Dr Gray to the report of Dr Orr prior to the hearing of November 2006 but it was accepted by Dr Orr in oral evidence that Dr Gray had never been asked to provide a response. Mr Colin contended that Dr Orr failed to provide any objective explanation as to substantial additional information available in November compared with May 2006 and which explained his change in view from contingent removal being appropriate to unconditional removal being appropriate. Mr Colin also made reference to Dr Orr's repeated reliance upon "lack of trust" (in the sense of confidence in Dr Gray's future actions) without clearly defining the reasoning for such or explaining why no such reference appeared in the written report or in the notes of the hearing on 2nd November 2006 (similar observations were made in relation to Mrs Dixon). In relation to the conditions (if thought to be appropriate in principle) Mr Colin drew attention to Dr Orr's acceptance that the prescribing policy subsequently drawn up was compatible with conditions 4, 5 and 6 but the evidence necessary to demonstrate practical application would require a lot of work from the PCT. Mr Colin indicated that conditions 1 and 2 would require involvement of Dr Gray's current partners, Dr Waseem and Dr Kamal, and Dr Orr accepted the fact of their recruitment (and no criticism was made of them or of their practice or approach to practice). Mr Colin further indicated that Dr Orr accepted that the Respondents have staff who would assist with matters relevant to conditions 7, 8 and 9 and that clinical supervision under condition 10 required evidence that meetings had taken place. Mr Colin also referred to Dr Orr's acceptance that the Quality and Outcomes Framework ("QOF") relating to the visit on 21st December 2006 was "positive" and "encouraging" and "painted a very different picture since May 2006".

16. Mrs Dixon was not a source of primary evidence but was called to (in effect) explain the reasoning of the PCT in reaching their Decision. Mr Colin reminded us that she accepted that the QOF report indicated a significant improvement. He also notes that she was not being objective when she said that the QOF report did not address issues surrounding the prescriptions and sick notes. Mr Colin referred to Mrs Dixon indicating "Who knows what might have happened" if all the information provided to the FHSAA by Dr Gray had been available in November 2006.

17. Dr Gray expressed both shame and regret in relation to his actions and letting people down and taking risks which he had no right to take. It was contended on his behalf that he showed genuine insight into his shortcomings in relation to Dr Orr's findings and could therefore be trusted to avoid such problems in the future with the imposition of appropriate conditions. It was accepted on his behalf that genuine insight was a relevant factor. Dr Gray was asked in cross-examination as to his perception of what he had done wrong and Mr Peacock summarises his answers to the effect of him referring to his own stubbornness and pride, blaming the Nurse Practitioner for going beyond her remit and blaming the PCT for not assisting either in relation to premises or recruitment of further doctors. It was noted by Mr Peacock and it was the case that Dr Gray indicated that the system for pre-signing of blank prescriptions was designed to reduce congestion : in other words it was a deliberate decision by Dr Gray to instigate use of pre-signed prescriptions by the Nurse Practitioner in the context of restricted space and numbers of doctors. He indicated that in relation to open surgeries (i.e. without appointments) run by him and the Nurse Practitioner for patients pre-signed prescriptions were available for her use in relation to medicines of a "basic" nature. He indicates that when he is away on holiday some locums were reluctant to sign repeat prescriptions and it was agreed that the Nurse Practitioner would sign such. Dr Gray explained in his evidence-in-chief that the Nurse Practitioner was not qualified to prescribe and that she did so "under the umbrella of my supervision". He did however accept that she had prescriptions available for use both when he was present and when he was not present. In cross-examination when asked to explain what he did wrong, Dr Gray indicated that he allowed a member of his staff to issue prescriptions when not qualified to do so, that he was too reliant upon flexibility of a Locum Service, and that he did not allow enough consultation time. He indicated when asked as to whether the Practice was

overall functioning well or not that at the time (in May 2006) he was convinced that he was doing a good job although he now accepts that cannot have been the case.

18. In relation to the Nurse Practitioner (not a nurse with prescribing rights) he was asked various questions and indicated that he recognised that it was wrong for a nurse to be giving prescriptions, that he knew it was wrong at the time but that he allowed it to happen for the benefit of the smooth running of the Practice and for the benefit of patients. He indicated that whilst he does not now think it was for the benefit of the patients he did think so at the time : he appreciated that it was not in the interests of the patients when it was pointed out (i.e. effectively when the PCT became involved in May 2006). He recognised the potential for problems such as interreaction with other drugs being given or there being contraindications to a particular drug. He indicated that at the time he considered there were sufficient safeguards in place but accepted that he was wrong. When asked as to the number of prescriptions which he had pre-signed when blank, he indicated that he had signed prescriptions in order to take account of possible demand for repeats and did not give any further explanation of the number involved. He indicated that the practice of using pre-signed prescriptions had gone on for about 2½ years. He indicated that the remit of the nurse (arising only from conversations with her rather than any formalised or written policy) was in relation to medication such as antibiotics or anti-inflammatories which can be bought over the counter. He explained in answer to Dr Walsh-Heggie's questions that recruitment of the Nurse Practitioner followed her attendance at the surgery enquiring as to the possibility of a job rather than him advertising. He indicated that at the time he did not know what a Nurse Practitioner was and asked her to explain her training and to provide her CV. He did not take up her references. He indicated that he decided to "give it a try" and that thereafter he found her clinically very good and she seemed to come to him with appropriate questions. He accepted there was no formal treatment plan available to her in relation to particular conditions and that there had been "discussions" as to the limited range of conditions in respect of which she should provide treatment including medication. He accepted that one of the sample prescriptions which had been made out while he was away in May 2006 was medication for hypertension (which is commonly known as an ACE inhibitor) and was in no sense routine or equivalent to medicines available over the counter.

19. Dr Gray accepted that other matters such as the need for locum cover and precise arrangements for the extent of locum cover were also left to the Nurse Practitioner and that he relied upon her very greatly.

20. Dr Gray indicated in one part of his evidence that the pre-signed prescription forms were kept under lock and key although in later parts of his evidence agreed that he did know such was the case and (in effect) assumed that such was the case.

21. In his evidence on 2nd May, Dr Gray had indicated that the pre-signed sick notes were used by the Nurse Practitioner in relation to patients who were suffering from chronic conditions. On the morning of 3rd May Dr Walsh-Heggie wished to clarify the evidence in such regard and by agreement Dr Gray was recalled to deal with such issue. Although his use of "chronic" was not precisely defined it appeared that he was not restricting his use of such word to conditions where there was duration of over six months (and in respect of which different forms can be used which negate the need for repeat attendances for certification). In the course of such explanation he was asked to explain the circumstances in which pre-signed sick certificates were used and he indicated that there were occasions when a locum doctor would refuse to issue or sign a certificate and the Nurse Practitioner might issue one of the pre-signed certificates after such refusal. He accepted that the forms were such as would require the doctor to certify the accuracy of the statement (which is a statement of examination and diagnosis causing absence from work).

22. More generally, Dr Gray gave evidence that he had had difficulty recruiting further doctors albeit that he had not used any formal advertising. He accepted that his List size of around 5,000 (since slightly reduced and on occasions having been the

subject of List closure for a few months) was well above the recommended size of 1,800 patients for each doctor. He indicated that he had by the time of the hearing in November drawn up a new repeat prescription policy. Reference was made on his behalf to the QOF report in December 2006. Such was in general terms a favourable report. We note that the report is upon the Practice as a whole and not upon an individual. In such a context the Clinical Assessor gave a summary : "With the staffing changes that have taken place the Practice has been under strain which is borne out by the current clinical achievement figures. To a large extent the Practice has been run by locums, peripatetic nurses and support from the pharmaceutical industry which makes continuity of care difficult as patients prefer to see familiar faces. The Practice is aware of the challenges it faces but is now in the positive position of having Dr Gray in a managerial support role to help support and drive clinical care forward in conjunction with the new partners. On review of the QOF Assessor Validation reports, some anomalies in data have been found. The information has been left with the Practice to enable them to review and amend where necessary. The Clinical Governance Team are happy to provide support if required and a follow-up review will take place before year end". The Nurse Clinical Assessor gave the summary : "The Practice is at present in transition from a single-handed to a Group Practice. There has also been a shortage of experienced Practice Nurse expertise that has resulted in structured chronic disease and patient education not reaching its full potential. There are key areas that need attention (high prevalence in a deprived area), these are CHD, diabetes and hypertension management, which need concentrated focus. These will hopefully improve with the help of a data input/recall clerk and concentration by all the team. All staff appear to have worked hard during recent times to ensure effective practice. Inroads have been made into organising the Practice and the future looks positive. With renewed enthusiasm and good communication that includes every grade of staff the Practice has the potential to succeed". The Managerial Assessor summary refers to the poor building (old and ill designed in modern context) and continues "The Practice has had staffing difficulties that are going to make achieving high QOF figures this year difficult. However the managerial support from Dr Gray, the new partners and the new nurse soon to be in place provides the Practice with the ideal opportunity to review current system and processes and decide how they would like the Practice to move forward collectively and build for the next and subsequent QOF years. It is important the Practice takes the time to ensure these systems and process are robust and imbedded, e.g. the further development of regular Practice meetings that combine administrative and clinical reviews to ensure that quality of care is at the centre of all activities. This way safe, sound systems can be established that optimise patient care provide opportunities for staff development and will be rewarded by good QOF achievement scores. As the Practice is yet to achieve all the indicators that would normally be reviewed as part of a QOF visit a further visit will be arranged before year end". The assessors referred to are all employed by or relied upon by the PCT.

23. It was drawn to the attention of both Counsel prior to their submissions that the NHS (General Medical Services) Regulations 1992 and in particular Regulation 24 impose a maximum of 3,500 patients per doctor : such is an absolute maximum subject only to conditions not applicable in this case.

24. We were provided with a publication of the Royal College of General Practitioners "Good Medical Practice for General Practitioners" (published 2002). Such is in large part reflective of the General Medical Council's "Good Medical Practice". We refer to it as indicative of generally accepted relevant standards. In the context of this case we note the following. In the introduction (page IX) it is said "It is and always has been a professional responsibility to provide a high standard of care. However doctors in the United Kingdom are increasingly expected to be able to demonstrate their fitness to practice". In chapter 3 "access, availability and providing care out of hours", it is said that "a flexible system with both booked appointments and open access may be best in some areas" and it is (inter alia) said that "the unacceptable GP..has no knowledge of the qualifications of locums employed in the Practice or ignores doubts about their ability..does not follow up relevant information about his or her patients that has been provided by another health professional". In chapter 6 "Keeping Up to Date and Maintaining Your Performance" it is said that a general practitioner must "take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your Practice, for example by undertaking further training" and it is said that (inter alia) "the unacceptable GP..does not audit care in his or her Practice or does not feed the results back into Practice..where employing staff neither understands nor meets his or her responsibilities as an employer". In chapter 11 "Working with Colleagues and Working in Teams" it is said that the general practitioner must "communicate effectively with colleagues within and outside the team..participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any defects..If you lead a team you must ensure that..regular reviews and audit of the standards and performance of the team are undertaken and any deficiencies are addressed". It is further said that "You must ensure that people you employ or manage are competent and trained for their jobs..A stand-in or locum GP also needs to be aware of the identity and role of other team members; it is the responsibility of principals to ensure good communication with locum doctors they employ and that relevant information is available to that locum in an easily accessible format..It is your responsibility to ensure that the person to whom you are delegating has the ability to provide the care required..In cases where a member of your staff is the first point of contact with patients, it is particularly important to ensure he or she has the training to provide the necessary care, and knows the limits of his or her competence". "The unacceptable GP..delegates tasks to other members of the team for which they do not have appropriate skills".

Decision

25. Although we shall in this Decision express concerns in relation to Dr Gray, we indicate at the outset that we do not accept any suggestion or implication that he acted for improper motives such as financial gain even with regard to matters where we hold that he behaved in an unacceptable way which has severe implications for his clinical practice and the safety of patients. We accept he did not act so as to consciously take risks of harm to patients. In lay terms we accept that Dr Gray always wished to help his patients.

26. As will be apparent from later parts of this Decision we are of the view that issues arising from signing blank prescriptions and blank sickness certificates are the most serious aspects of the case and we shall deal with them first.

27. In relation to both prescriptions and sickness certificates it is to be noted that the powers to sign prescriptions and to certify sickness justifying absence from work are amongst the very few powers whose exercise is limited to qualified doctors (together with nurse prescribers in relation to prescriptions). There is nothing reflected in "Good Medical Practice for General Practitioners" otherwise from a wider consideration of professional medical practice to remotely justify the practice of signing such documents in blank and then allowing an unqualified person to complete such documents, and moreover to do so without immediate supervision on a case by case basis.

28. In relation to the signing of blank prescription forms for later use by the Nurse Practitioner it is to be noted that such was a system of working adopted over a substantial period of time of about 2½ years and involved a very substantial number of prescriptions. Approximately 2,000 blank pre-signed prescriptions were recovered from the surgery premises. Dr Orr's investigations have included recovery of nearly 500 prescriptions dispensed by two locum pharmacists during a week at the beginning of February 2006 when Dr Gray was on holiday and demonstrated that 94 bore Dr Gray's signature but were dated at a time when he was on holiday. The only "explanation" put forward by Dr Gray was that the arrangement eased congestion in an understaffed and under resourced surgery. We are of the view that such action and such system is such that even a moment's thought on the part of a general medical practitioner should result in the conclusion that it was absolutely and unequivocally wrong to use prescriptions in such a way. Whatever the pressures of time or resources not only formal training but also innate professional ethics should immediately indicate that such action is unequivocally wrong. It is plainly in breach of contract as well as professional standards. We acknowledge Dr Gray's open (if inevitable) acceptance that the Practice was wrong but he gives no explanation (and we suspect there could be no explanation even in circumstances we cannot presently imagine) which could render his practise in relation to pre-signed blank prescription forms understandable nevermind reasonable or acceptable.

29. The individual circumstances involving the role of the Nurse Practitioner employed by Dr Gray aggravate rather than mitigate the actions. Dr Gray made almost no formal investigation of the individual Nurse Practitioner and seems to have had little if any knowledge as to the background and training of Nurse Practitioners in general save what she told him. We have not heard from the nurse in question but the nature of the relationship is plainly such that Dr Gray was the senior and responsible person and insofar as the nurse played any active part in the practise of use of pre-signed blank prescription forms (and it has not been suggested to us that she was the instigator) Dr Gray had a clear duty to restrain her enthusiasm insofar as it went outside the bounds of her professional competence and powers.

30. We find it difficult to imagine circumstances in which Dr Gray could give an explanation of the practise in relation to prescriptions which was consistent with any professional consideration of the potential risks to patients if inappropriate drugs were given even if one were to disregard (which we do not) the clear ethical and legal aspects of prescriptions being given otherwise than by those legally entitled to give prescribed medicines.

31. The extent of use of pre-signed sickness certificates, namely signed in blank by Dr Gray and then used by the Nurse Practitioner, is not as clearly defined in the evidence as that relating to pre-signed prescription forms. There were a number of such forms recovered from the surgery premises and Dr Gray accepted that there had been such a practise for some time even though the period was not clearly defined. The initial indication of such use was in the context of the nurse giving repeat certificates for patients with chronic conditions. Clarification on the final day of hearing did however reveal that some pre-signed certificates were used in the quite different and more serious circumstances of being given (plainly to the knowledge of Dr Gray as he was the source of the evidence) when a locum doctor had in the absence of Dr Gray refused to give a sickness certificate. In other words a sickness certificate was being given which by its wording purported to be a doctor's confirmation of an examination leading to advice to refrain from work on the basis of a stated diagnosis, when in fact not only had a doctor not examined and confirmed a diagnosis of justifying absence from work but a doctor had in fact consciously refused to give such certificate. Such is self evidently grossly misleading to all those who rely upon sickness certificates.

32. Whereas Dr Gray explained that pre-signed sickness certificates were to be used by the nurse in the context of locums refusing to give a certificate in relation to chronic conditions, there was no explanation of the use of such certificates in a context of a conscious refusal by a locum to give a certificate after the locum had seen the patient. Having received legal advice in the context of the potential seriousness of any further answers, Dr Gray exercised his right not to answer further questions upon the topic.

33. It is self evident that there are risks of use of the pre-signed prescription forms by people other than the Nurse Practitioner in the event of theft from the surgery premises. The same observation applies to the sickness certificates. It is moreover to be noted that the Respondent submitted and the Appellant did not dispute that the sickness certificates have potential notable financial value not only in the immediate sense of their value to the person receiving a sickness certificate but a commercial value if blank pre-signed sickness certificates got into hands which sought to sell them.

34. Such explanation as was given in relation to the practise of pre-signing blank sickness certificates could not justify their use even in the context of being repeat certificates for patients with chronic conditions but there was no explanation in relation to the even more serious use of such certificates when a locum doctor had consciously refused to give such certificate having seen the patient.

35. Before considering the other findings and grounds relied upon by the Respondent we consider the impact of the evidence other than that of Dr Gray upon the two foregoing issues. We entirely accept that Dr Gray appears to be a popular general practitioner whose patients appreciate and trust him. We accept that the two partners who have joined Dr Gray in practice since November of last year are young and enthusiastic doctors who have genuinely held ambitions and plans to improve the Practice. We accept that the QOF report indicates that the Practice (as opposed to Dr Gray individually) has reasonable prospects of correcting previous areas of poor practice and ensuring appropriate recruitment of relevant staff and adoption of proper policies in relation to drugs and training and audit of staff (amongst other matters). We do not take the view that any such matters impinge upon the issue as to whether Dr Gray personally can be considered to have changed or be likely to change to such extent that such inefficient and unethical practice as has occurred in relation to pre-signed prescription forms and sickness forms has been addressed by him so as to give a basis for confidence that in the future no comparable failings, which have potential serious impact upon safety and trust of patients, will be repeated.

36. We are invited to have regard to the observations by the FHSAA Panel hearing the case of Dutt v Huddersfield Central PCT (Case No: 12359) who in paragraph 96 said: "In order to address the findings of the Panel in relation to his inefficiency the Appellant would need to first acknowledge the difficulties that he faces. In the course of these proceedings the Panel has not found there to be significant evidence demonstrating that the Appellant acknowledges the extent of his inefficient practice or that he has the ability or willingness to change. No substantial evidence has been adduced to support a submission that the imposition of conditions would have a realistic prospect of removing the prejudice to the efficiency of the services. Nor can the Panel find significant evidence of the Appellant engaging in reflective practice in the course of his clinical management of his patients or his practice generally. In those circumstances the Panel is unable to identify any conditions which could be imposed with a view to removing any prejudice to the efficiency of the services in question".

37. Dr Gray's failings in relation to the use of pre-signed blank prescription forms and sickness certificates were fundamental failings. They do not require any form of written policy or audit or formal analysis to lead to the conclusion that they are self evidently wrong and carry risk to patients and prejudice to the efficiency of the provision of services. They raise fundamental issues of professional integrity. His conduct was on a substantial scale and over a substantial period of time. Whilst Dr Gray has in effect said that he will comply with any conditions which are imposed and give any undertakings necessary we would in the context of such fundamental failings require extremely strong and persuasive evidence to demonstrate that he genuinely has insights into his failings and genuinely accepts the unacceptability of such practice. In reality we would require some "explanation" which truly and rationally "explains" how or why Dr Gray ever thought such practices could be considered

acceptable and safe. There is no significant evidence of him engaging in reflective practice.

38. We doubt that explanations could be given to adequately explain such fundamental failings which persisted over a period of time and were systemic to Dr Gray's practice. In any event we are not satisfied that we have received any explanation in the course of the case and in our opinion contingent removal and imposition of conditions would not be appropriate. There are some areas of inefficient practice which are so fundamental, especially when pursued over a long period of time, as to render contingent removal inappropriate.

39. The other findings by reference to which the Decision of the PCT to remove Dr Gray was made involve important and serious matters. We do not deal with them at length save to say that if they had stood alone and the issues as to pre-signed blank prescription forms and sick notes were not present, it would in our opinion have been appropriate to deal with the matter by reference to contingent removal and imposition of conditions along the lines of those referred to in Dr Orr's report. We do not consider such matters at greater length because such is academic in view of our previous conclusions.

Summary

40. We dismiss the Appeal of Dr Gray and uphold the Decision of the Respondent PCT to remove Dr Gray from their Medical Performers List pursuant to Regulation 10(3) and (4)(a).

41. In accordance with Rule 42(5) we notify the parties that they can appeal this Decision under Section 11 of the Tribunals and Inquiries Act 1992 by lodging Notice of Appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days of the date of this Decision.

42. As was agreed with Counsel representing both parties at the hearing, we will consider the issue of national disqualification after receipt of further submissions by the parties after they have read this Decision. Those submissions may be oral or in writing.

22nd May 2007

CHRISTOPHER LIMB
Chairman