Case No. FHS 15153

IN THE FAMILY HEALTH SERVICES APPEAL AUTHORITY

Mr. D Pratt - Chair
Dr D Kwan- Professional Member
Mr W Nelson - Member

2 July 2009

BETWEEN:

WALTHAM FOREST PRIMARY CARE TRUST

Applicant

-and-

DR ARIF MAHMOOD

(GMC No. 5172102)

Respondent

DECISION AND REASONS

1. This is an application by Waltham Forest Primary Care Trust ("the PCT") for:
    a. the National Disqualification of Dr Arif Mahmood ("Dr Mahmood") from inclusion in any Performers List maintained by a PCT, under Regulation 18A (3) of the National Health Service (Performers Lists) Regulations 2004 ("the Regulations"); and
    b. an extension of the two year review period after which Dr Mahmood can otherwise request a review of national disqualification, pursuant to Regulation 19 (a) (as amended).
2. The PCT's applications follow its decision to remove Dr Mahmood from its own Performers List, on 18 February 2009, as it was obliged to do under Regulation 26 (1) (c), because it had been notified by the General Medical Council that the GMC's Fitness to Practise Panel (FTPP) had on 30 January 2009 suspended Dr Mahmood's registration with immediate effect under Section 38 (1) of the Medical Act 1983. The FTPP had found, on that date, that Dr Mahmood's fitness to practise was impaired by reason of his misconduct and adverse physical or mental health.
3. We heard evidence and submissions on 2 July 2009 at the General Chiropractic Council, 44 Wicklow Street, London WC1X 9HL, when the PCT was represented by Mr Matthew Barnes, of Counsel, instructed by Capsticks, solicitors, and Dr Mahmood was represented by Mr Giles Colin of Counsel, instructed by the Medical Defence Union. That hearing

concluded after 5 pm and it was necessary to convene the Panel on a later date to consider its decision.

4. At the outset of this hearing we invited Mr Colin to consider whether he had any application for any part of the evidence or proceedings to be taken in private having regard to the matters bearing on Dr Mahmood's health, but after taking instructions he did not ask us to do so.

DECISION

5. Our unanimous decision is that:
    a. Dr Mahmood be disqualified from inclusion in any Performers List prepared by a Primary Care Trust, or supplementary list as is referred to in Regulation 18A (1) of the 2004 Regulations, as amended; and
    b. The application for extension of the review period is dismissed.

REASONS

The Legal Framework

6. By Regulation 26 (1) of the 2004 Regulations:
"Subject to paragraph (2) …. the Primary Care Trust must remove a medical practitioner from its medical performers list where it becomes aware that he is –
….(b) the subject of an order or directions made by [the Professional Conduct Committee of the General Medical Council] under section 38 (1) of [the Medical Act 1983] (order for immediate suspension)."
The exception contained in paragraph (2) is where the suspension is made in a health case.
7. By Regulation 18A (3) of the 2004 Regulations:
"A Primary Care Trust which has – (a) removed a performer from its performers list…. may apply to the FHSAA for a national disqualification to be imposed on him."
8. If national disqualification is imposed, the practitioner may not request a review until two years have expired, and thereafter at yearly intervals: see Regulation 18A (8) of the 2004 Regulations. However, the FHSAA may direct that a period of five years be substituted for the review period of two years if it "states that it is of the opinion that the criminal or professional conduct of the performer is such that there is no realistic prospect of a further review being successful, if held within the period [of two years]": see Regulation 19 (a).
9. There is no statutory guidance on the factors to be applied in considering national disqualification. It is available whether the ground for removal is a mandatory or discretionary one, and if discretionary, whether it is on grounds of suitability, fraud, or efficiency. In our view these wide powers are conferred on us so that we can deal with the multiplicity of different factual situations which arise without the necessity to pay undue regard to the label attached to the conduct or deficiency.

10. The "Advice for Primary Trusts on Lists Management" published by the Department of Health in 2004 says at paragraph 40.4 that a PCT should "*recognise the benefits of a national disqualification both for protecting the interests of patients and for saving the NHS resources"*. It says further that *"this additional sanction is necessary in the most serious cases, only when a doctor has been ….removed by a PCT from its own list, and it is imposed by the FHSAA"* and *"unless the grounds for removal … were essentially local, it would be normal to give serious consideration to such an application"*.
11. The principles derived from published Guidance and from cases determined by the FHSAA to date establish, in our view, that:
    a. Serious consideration should be given to national disqualification where the findings against the practitioner are themselves serious and are not by their nature essentially local to the area where the practitioner was working;
    b. Other relevant factors are:
        i. The range of the deficiencies or misconduct identified;
        ii. The explanations offered by the practitioner;
        iii. The likelihood of those deficiencies or conduct being remedied in the near to medium term;
        iv. Patient welfare and the efficient use of NHS resources; but balancing those against -
        v. The proper interests of the practitioner in preserving the opportunity to work within the NHS (which includes both pursuing his professional interests and earning money).
        vi. Whether national disqualification is proportional to the mischief of the Panel's findings as to the conduct or clinical failings of the practitioner, and to consider the common law requirement that national disqualification is reasonable and fair (see *Kataria v Essex SHA* [2004] 3 AER 572 QBD).
    c. The standard of proof which we should apply is the balance of probabilities, in accordance with the guidance of the House of Lords in *Re D* [2008] UKHL 33.

<u>Documents</u>

12. The Panel had a pre-hearing bundle comprising documents submitted by the PCT (numbered A1- A25) and by Dr Mahmood (numbered R1 – R56). These included written summaries of the submissions the parties. At the hearing we were additionally provided by the PCT with a skeleton argument from Mr Barnes, and a copy of a section of the British National Formulary which was numbered A26 - A32, and by Dr Mahmood with a letter dated 26 May 2009 by way of report from Dr Gerada, of the NHS Practitioner Health Programme, numbered R57 – R59.

<u>Background</u>

13. Dr Mahmood (now aged 45) told us that he qualified MBBS in Pakistan in 1990 and began his medical career in the UK in 1994, in various training posts and also took Part 1 MRCP exams and the PLEB parts 1 and 2. He

worked in various hospital posts including a period of 3 years in Barrow-in-Furness during which he took the MRCP Part 2. In 2003 he commenced training as a GP, and completing GP training in February 2004. He then worked in the Waltham Forest PCT area in various locum posts before taking up a part time post as a salaried GP at the Tollgate Lodge Primary Care Centre, Stamford Hill, London ("Tollgate") from 14 August 2006 to 2 February 2007.

14. The subsequent history is shown by the findings of the GMC Fitness to Practise Panel ["the FTPP"], which Dr Mahmood expressly accepts, as we established when we sought clarification of paragraph 5 of his written Response to the PCT's application [page R3]: "Dr Mahmood does not seek to go behind the determination of the FTPP dated 30th January 2009", and we find the following facts to be proved, subject to the additional findings we set out at paragraph 99 and following in this decision. The adverse findings arose out of two separate episodes of professional conduct:
    a. Use of, and accounting for, injectable diazepam; and
    b. Obtaining dihydrocodeine on bogus prescriptions.

    We also interpolate some supplementary information derived from medical reports submitted on behalf of Dr Mahmood, indicating the source where different from the FTPP.

    a. Diazepam

15. On 15 November 2006 (3 months after Dr Mahmood started in post) a stock take at Tollgate revealed that 5 vials of diazepam were missing. However the medical report of Dr Checinski [page R7] sets out an account given by Dr Mahmood, that 23 10 mg vials were found to be missing, and that around this time Dr Mahmood resigned his post over a dispute about pay and conditions. On 1 December 2006 a further stock-take revealed that 5 vials of diazepam were missing. On 14 December 2006 Dr Mahmood handed 9 diazepam vials to the Tollgate Practice, stating he had been carrying them in his bag. However, examination of the vials showed that they were not ones which had come from the Tollgate Practice. An investigation was commenced.

16. During the investigation Dr Mahmood gave 4 different oral explanations:
    a. He stated that one possible explanation was that the Tollgate Practice diazepam stock had been administered by him to patients at another practice, and he had replaced the stock with stock from another practice.
    b. He gave another possible explanation that the drugs had been used for patients within the Tollgate Practice but he had not recorded the details.
    c. He gave a third explanation that the diazepam had been administered to his brother, who was registered with him at a different practice.

d. On 18 January 2007 he stated he had used the diazepam in “dribs and drabs” for different patients and he believed the stock control may have been incorrect.

17. Dr Mahmood subsequently admitted to the FTPP that his oral statements were misleading.
18. On 26 February 2007 Dr Mahmood made a signed written statement that he had administered injectable diazepam to a number of patients at the Tollgate Practice, but had not recorded its administration in any of the patients’ records, and that he had also administered diazepam to a member of his family who was registered as a patient at another practice. Dr Mahmood admitted to the FTPP that his actions described in that statement were inappropriate, irresponsible and not in the best interests of his patients.
19. In his evidence to the FTPP Dr Mahmood adopted the explanation he had given in his February 2007 statement but as they found “could offer no plausible account as to why [he] previously offered other misleading statements”.
20. Dr Mahmood further told the FTPP that despite have spent almost 3 years in general practice, including 12 months training as a registrar, he had never used diazepam by injection in general practice prior to arriving at Tollgate. An expert witness gave evidence that diazepam by injection rarely needs to be used in general practice. Dr Mahmood stated he used diazepam because of its ready availability at Tollgate, and used it several times over a short period. He said he had not used it previously because of its lack of availability at other practices. The FTPP “doubt[ed] the credibility of this explanation”.
21. Dr Mahmood told the FTPP that he did not record the injections of diazepam because he regarded them as secondary to the main reason for consultation, for example the need to provide relaxation prior to an injection into a joint. He also explained he was under pressure to deal with patients quickly and was not fully trained in the use of the software at Tollgate Practice. The FTPP found it “inexplicable that you failed to record the secondary treatment [on any occasion] but were capable of recording the primary treatment, particularly given the importance of accurate record keeping.”
22. It is inescapable that the FTPP did not find Dr Mahmood’s explanations summarised at the two preceding paragraphs, acceptable. We agree with the necessary inference that on balance they are untrue.

<u>b. Dihydrocodeine</u>

23. In November 2007 Dr Mahmood began work as a locum at Becontree Medical Centre, Dagenham, Essex (“Becontree Centre”). At that time he was subject to GMC proceedings arising from the diazepam matters, and an Interim Orders Panel had imposed conditions on his registration (see below). On 2 November he brought QA to Becontree Centre, and asked that he be registered as an “immediate and necessary patient”. Between 2 and 24 November 2007 (starting almost as soon as he commenced

working at the Centre) Dr Mahmood issued 5 prescriptions in the name of QA for a total of 379 dihydrocodeine tablets (30-40 mgs). Dr Mahmood admitted to the FTPP that those actions were inappropriate and irresponsible. Those prescriptions were in fact for Dr Mahmood. Some were subsequently stopped or cancelled after he was challenged as set out below. Dr Mahmood admitted to the FTPP that these actions were dishonest, inappropriate and irresponsible.

24. On 19 November 2007 Dr Mahmood issued a prescription in the name of QA for 100, 30 mg dihydrocodeine tablets. He made no record of the prescription and destroyed the handwritten copy. He admitted to the FTPP that these actions were inappropriate and misleading. The computer generated copy of the prescription in the name of QA was presented at Tesco Pharmacy, Gallows Corner, Romford, by Dr Mahmood. It was queried because the amount of dihydrocodeine to be dispensed was thought to be excessive. The pharmacy contacted the surgery, which responded that, according to computer records, no such prescription had been issued. The pharmacy was asked to return the prescription and ask the patient (purporting to be QA) to return to the surgery. QA did not attend the surgery, but Dr Mahmood did, and queried why the pharmacist had been instructed not to dispense the prescription. When Dr Mahmood was told that there was no record that the prescription had existed, he falsely sated that there was no record because it was a private prescription. He admitted to the FTPP that this conduct was inappropriate, misleading and dishonest.

Subsequent events, FTPP proceedings and medical treatment

25. Dr Mahmood worked out his notice, leaving Tollgate Centre in February 2007. He next worked for an out-of-hours service, starting in May 2007 [R7]. The apparent misconduct over the vials of diazepam was referred to the GMC by Dr Mahmood's former employer and in July 2007 conditions were placed on his registration by an Interim Orders Panel, including a restriction so that he was not able to prescribe injectable medication. In the same month, his own GP prescribed anti-depressant medication (initially citalopram then ventafaxine) [R8]. There is no recorded history of depression before that period.
26. Other relevant medical history is that Dr Mahmood had polio as a child and in consequence has a deformed leg which has in turn caused lumbar pain. He has had steroid injections for back pain and told Dr Checinski that he had also been prescribed dihydrocodeine for back pain by his GP, starting in1998. His account to Dr Checinski was that his GP was prescribing dihydrocodeine in November 2007 and he wanted to supplement the dose primarily to achieve mood elevation and to take his mind off suicidal ideas.
27. The Becontree Centre also reported Dr Mahmood to the GMC and to the PCT, because of his conduct over prescriptions of dihydrocodeine. The matters proceeded in tandem.

28. The GMC matters came before the FTPP on 26 - 30 January 2009. Their extensive determinations are more fully set out at pages R42-R55. It is right to say (as Mr Colin's submissions reminded us) that Dr Mahmood made admissions of dishonesty, inappropriateness, irresponsibility and actions not in the best interests of patient and below the standards of Good Medical Practice. All he did not formally admit, so far as we can see, were the consequential allegations of misconduct and adverse physical or mental health, both of which were found proved. The FTPP found that his fitness to practise was consequently impaired, *by reason of his misconduct,* pursuant to Section 35C (2)(a) of the Medical Act 1983*,* and also *by reason of his adverse physical and mental health,* pursuant to Section 35C (2)(d) of the Medical Act 1983 [R49]. In this case the FTPP determined that the appropriate sanction was suspension for a period of 3 months. It further directed that a review of the case would take place before the end of that period to consider various reports mainly directed to the health issues. It also determined that his registrations should be suspended forthwith under Section 38 of the 1983 Act, with the further result that Dr Mahmood was removed from this PCT's Performers List.
29. Meanwhile Dr Mahmood had contacted the Sick Doctors Trust and started attending meetings of the British Doctors and Dentists Group in December 2007. He is said to have attended 90% of their meetings. He consulted his GP about stopping dihydrocodeine and was switched to tramadol for pain control. We are told he took his last dose of prescribed dihydrocodeine in July 2008. He was also referred to a Consultant Psychiatrist whom he saw every 2 months from November 2008 to March 2009, when he found Dr Mahmood to be "quite well from a psychiatric point of view" and advised he should attend for follow up in 5 or 6 months time [R27].
30. As a result of GMC health procedures, Dr Mahmood was also seen by two GMC appointed experts, Dr Checinski (Hon Consultant Psychiatrist in Addictive Behaviour) and Dr Savla (Consultant Psychiatrist) whose reports have been made available to us by Dr Mahmood (R7 –R19). They were considered by the FTPP when it reviewed his case shortly before the end of his suspension. He has also referred himself to the Practitioner Health Programme, an NHS service for doctors or dentists living within the London area, with mental health, addition or physical health problems. Its medical director, Dr Clare Gerada, provided letters dated 23 March and 26 May 2009 within our bundle at R20-21 and R57-59. She also gave evidence to us.
31. Dr Checinski's report of 24 March 2009 concluded [R11] that Dr Mahmood suffered moderate depressive episode (ICD-10, F32.1) which had responded well to treatment and was in remission. In addition he diagnosed ICD-10, F11.2, mental and behavioural disorder due to the use of opioids, dependence syndrome including the abuse of dihydrocodeine. He concluded that the opioid dependence was in remission and the prognosis for both conditions was good. His supplementary report of 16 April [R12] set out the results of hair testing for drug misuse, covering the

approximate period December 2008 to mid-March 2009. These were negative for benzodiazepines, cannabis, cocaine, and opiates, and confirmed the presence of tramadol in appropriate therapeutic levels as prescribed by his GP. Dr Gerada's report dated 26 May 2009 also provided evidence [R58] that tests on Dr Mahmood urine and hair which were negative for abuse of opiates, barbiturates and benzodiazepines. Dr Savla's report of 17 March 2009 concluded, among other things [R17] that Dr Mahmood had suffered symptoms of affective disorders and depressive illness as defined in ICD-10 under F32.1/2. He also diagnosed substance abuse as defined by ICD-10 under F11. In his view both disorders were currently in remission, and his pain disorder was under control.

32. Dr Checinski and Dr Savla were asked by the FTPP to express an opinion on any continuing impairment of Dr Mahmood's fitness to practise. Dr Checinski expressed the view [R11] that it was impaired and that he required medical supervision; he made more detailed recommendations about attending the Practitioner Health Programme and seeing a Consultant Psychiatrist, and undergo regular hair testing for drug abuse. He also recommended limitations on his practice so that he should not work in short term locum positions, and that any locum or out of hours work should allow broad oversight of his practice. Dr Savla's opinion was that Dr Mahmood was fit to practise without specific restrictions [R18] although the FTPP subsequently noted the anomaly that he nevertheless recommended that DR Mahmood should continue to be treated by a Consultant Psychiatrist, continue to have random hair and blood tests, continue with a self-help group and continue to see a GMC appointed psychiatrist every three to four months [R33].
33. It is of course necessary to keep in mind that these reports were directed solely to the medical issues of the impact of any drug abuse or related health issues on Dr Mahmood's fitness to practise.
34. With these reports before them, the FTPP reviewed the case on 5 May 2009. It concluded [R34] that at that review date, Dr Mahmood's fitness to practise remained impaired by reason of his adverse physical and mental health, but not by reason of misconduct. The suspension was lifted and conditions on his registration were substituted, including that he must:
    a. Confine his practice to GP posts within the NHS under the supervision of a named GP Principal and not undertake any private practice;
    b. Not undertake any locum posts of less than 1 months duration;
    c. Obtain the approval of his medical supervisor before accepting any post for which registration with the GMC was required;
    d. Keep his professional commitments under review and limit his practice in accordance with his medical supervisor's advice;
    e. Cease work immediately if his medical supervisor advised him to do so;
    f. Not prescribe for himself or his family.

There were some further conventional conditions relating to future employments, and additional conditions relating to the management of his health, including remaining under the supervision of a medical supervisor nominated by the GMC, remaining under the care of a treating psychiatrist and complying with arrangements made on behalf of the GMC for random testing of blood, urine, and/or hair for ingestion of drugs.

35. These conditions are expressed to operate for 12 months from 5 May 2009 and will be reviewed before their expiry by a further FTPP.
36. In addition to the medical reports put in by Dr Mahmood, he provided us with letters from a Dr Hussain, at a surgery address in Essex, stating [R22] that Dr Mahmood had attended his surgery to observe consultations and discuss issues, had attended home visits with Dr Hussain and some postgraduate teaching sessions and had also attended a resuscitation skills course at the surgery. His letter said he had discussed the GMC case with Dr Mahmood and offered the opinion that he was remorseful and had taken steps to avoid "these mistakes" in the future. A subsequent letter of 23 April [R29] said that Dr Hussain would be happy to offer Dr Mahmood locum/ salaried employment once his GMC suspension was over.

<u>The main issues raised on the papers</u>

37. In summary, the PCT's written application (supplemented by Mr Barnes' skeleton argument) relied on the following factors [see A6 -7 and PCT skeleton argument]:
    a. He acted dishonestly in relation to the diazepam use by (i) attempting to reintroduce 9 diazepam vials to cover up any activity he was engaged in; and (ii) actively misleading the investigators of the missing diazepam at Tollgate and (iii) seeking to cover his use of injectable diazepam by omitting to enter relevant clinical information in the patients' notes; and (iii) being unable to offer the FTPP any plausible explanation. He behaved dishonestly in relation to the prescribing of dihydrocodeine by (i) making out prescriptions in the name of QA when some of them were in fact for him, and then stopping or cancelling some of them; and (ii) making no record of the prescription for QA on 19 November 2007, destroying the handwritten copy presented at the pharmacy, challenging the return of the prescription and falsely stating there was no record of the prescription because it was a private prescription.;
    b. He disregarded patient safety. Use of injectable diazepam is indicated in relatively rare circumstances. It may carry side effects including impaired breathing. His use of it was inappropriate and put patients at increased risk of harm. His failure to record its use in the notes also represented a risk to patients. In relation to his alleged use of dihydrocodeine the amount he ordered was manifestly excessive and such quantities represented a risk to patients.

c. He abused the trust placed in him by the NHS by putting his own interests before those of patients, deliberately misleading colleagues and providing treatment that posed a risk to patients.
d. This was serious misconduct involving deceit over a number of months, which was incompatible with the performance of primary medical services.
e. There were two separate and entirely unrelated episodes of serious, calculated and persistent misconduct, the second of which occurred whilst under restriction on his practice imposed by an Interim Orders Panel of the GMC.
f. The matters before the FTPP were not local in nature, and in fact and in several locations where he was working. By virtue of being on the Performers List of this PCT he was entitled to work as a locum in any PCT area.
g. The claim to have demonstrated insight into his failings was not supported by the various medical reports submitted by him, in which he is recorded as essentially accepting only an error in record keeping.
h. The medical evidence did not appear to be an explanation or justification for his actions.

38. Dr Mahmood's written Response asserted that National Disqualification was not appropriate in the circumstances of this case, and that he did not seek to go behind the determination of the FTPP dated 30 January 2009 (see clarification above). It continued that in order to consider his case fully, it was necessary for us to consider the private determination of the FTPP relating to health issues and that full version was placed in the bundle. He submitted that:
    a. He had admitted dishonesty, inappropriateness, irresponsibility and actions not in the best interests of patients and below the standards of Good Medical Practice;
    b. The background to the facts admitted and found proved by the FTPP was depressive illness and opioid dependency, currently abstinent;
    c. His misuse of dihydrocodeine commenced from about November 2007;
    d. These factors go a long way to explaining but not excusing his actions.

    We were also asked to consider the FTPP review hearing on 5 May 2009 and the various medical reports and letters contained within our bundle and to which we have referred above. Lastly it was submitted that any period of National Disqualification, if imposed, should not exceed 2 years.

<u>The PCT's case at the hearing</u>

39. Mr Barnes drew our attention to his skeleton argument and amplified some of the points.

40. As to the diazepam, he pointed out that the first thing Dr Mahmood did when challenged about the missing vials was to produce 9 vials from his bag, claiming he was returning them to stock, but in fact they came from elsewhere and we still don't know from where. He went on to offer investigators several false or misleading explanations for the missing vials, before asserting in his written statement of February 2007 that he had used them to inject patients he had treated, but had not noted doing so in any case. This was irresponsible patient care. In this context he also drew attention to the British National Formulary [A27] setting out the indications and dose for use of intramuscular injection of diazepam: "for severe acute anxiety, control of acute panic attacks, and acute alcohol withdrawal, 10 mg ….". He termed these situations "discrete and unusual" in General Practice. He submitted that Dr Mahmood had not used diazepam before and had not made a note of his use of it so it was not possible to say if the appropriate indications were present for the patients who had receive it, but he must have been using it a lot over a short time, given the number of vials which were missing. In fact he submitted that the PCT did not accept the "final explanation" given by Dr Mahmood for the missing vials.
41. Mr Barnes also submitted that Dr Mahmood could not demonstrate insight into his own failings on the material submitted to this Panel, as the medical reports established only that he regarded his failings in relation to the diazepam as merely a failure of good note keeping, which fell a long way short of the true mischief.
42. In relation to the dihydrocodeine matters Mr Barnes submitted that Dr Mahmood issued the first bogus prescription on the first day of work at the Becontree Practice, and furthermore while he was under investigation for the earlier matter by the GMC and subject to IOP conditions. He further amplified the submissions set out in his skeleton, submitting that these were serious, premeditated and persistent incidents of dishonesty.
43. Mr Barnes submitted that the medical reports provided some mitigation in relation to events during this period but did not relieve him of responsibility. He expressed the PCT's concern that if he was afflicted by depressive illness, he did not seek appropriate help but self-medicated using dihydrocodeine improperly prescribed for a patient; this despite being prescribed the same drug for pain control by his GP.
44. He submitted that Dr Mahmood's dishonesty was not really addressed by the conditions to which he was subject by the GMC. But any PCT which might employ him would have a burden placed on its resources, because of the conditions currently in force (the supervision of a named GP principal and so on). In view of the GMC findings the supervisor would need to ensure that his notes were accurate, or that his prescriptions were properly made out to appropriate patients. In addition a PCT would not be employing Dr Mahmood directly and he would be able to operate (as a locum) at some distance from the PCT whose Performers List he was on, by way of example if he were to be employed as a locum by Dr Hussain in Essex.

Dr Mahmood's case at the hearing

45. Dr Gerada was called on behalf of Dr Mahmood. She is currently the Medical Director of the Practitioner Health Programme (PHP) [see above]. She has the qualifications FRCP, FRCGP and also MRCPsych. She was awarded the MBE for services to the treatment of substance misuse. She told us she had experience as a GP and also had nationally recognised expertise in substance misuse. She described herself as a national lead in primary care in substance misuse. She was the director of primary care for the national clinical support team. She explained that PHP was a response to the fact that doctors and dentist suffer significant health problems (evidenced by high rates of suicide and alcoholism) without adequate practical access to healthcare. This was a 2 year pilot scheme set up by the Chief Medical Officer. Dr Gerada had seen 150 sick doctors and dentists which PHP managed as an integrated mental health service, getting them back into work with remarkable success and providing reassurance to PCTs that PHP supervises them. She said they also have an eye on patient safety.
46. Dr Gerada explained how Dr Mahmood had approached her after she had addressed a meeting of the British Doctors and Dentists in January 2009. He had subsequently attended as described in her letters, and Dr Gerada had taken a history and identified the issues, as well as testing compliance and counselling. She had asked permission to do an appraisal of Dr Mahmood (using the toolkit) because it was a problem to arrange for doctors who were not currently in work. It had given rise to no concerns: she referred to her letter at R21.
47. Dr Gerada conceded she would not be able to examine his case notes or practice but could monitor his mental state, and his drug testing.
48. She explained that she would be surprised if Dr Mahmood had been taking the injectable diazepam himself, because in her experience it was misused as part of a "poison cocktail" by drug users at the extreme end of the scale, in conjunction with heroin and other substances. Such drug abusers would either be asleep or "spaced out" and unable to hold down a job.
49. Dr Gerada told us that in relation to the allegedly premeditated use of bogus prescriptions for dihydrocodeine, Dr Mahmood was going through the GMC process and there was a record of his feeling suicidal and being prescribed anti-depressants. She said an altered mental state can make people act irrationally. It was her view that the altered mental state of shame plus the fact that he needed dihydrocodeine made Dr Mahmood do it. She made the point that doctors are very bad at seeking help.
50. Dr Gerada told us that doctors who are recovering addicts do very well with treatment. 80% are abstinent after 2 years compared to 20% of the general population. She judged that the prognosis was good because Dr Mahmood had a good pre-morbid profile: hard working, a range of skills and popular with patients [he told her]. In relation to the conditions to

which he was currently subject, she did not think they would impose a significant burden on a supervising GP.

51. In answer to questions from Mr Barnes Dr Gerada said her focus was on the health side, and conceded that the earliest evidence of mental health problems was in early 2007 and that they therefore had no relevance to the diazepam issues.
52. She further accepted the findings of the FTPP at paragraph 4 of page R52, namely that at the time of Dr Mahmood's dishonest prescribing [of dihydrocodeine] his judgement was not so seriously affected by his depression or opioid dependence that such dependence was the driving force behind his actions, and that he was aware that what he was doing was wrong, both with regard to obtaining the prescriptions and his attempts to cover up his actions.
53. Dr Gerada told Mr Barnes that she doubted Dr Mahmood was taking dihydrocodeine for the hedonistic effect (or mood elevation as Dr Checinski had found in his report to the GMC). She also thought Dr Mahmood had insight but described this as being "in relation to the shame of having committed both offences; the record-keeping of the diazepam and [the bogus prescriptions of dihydrocodeine]". This answer was in keeping with Dr Gerada's written reports based on her understanding of the GMC proceedings derived from Dr Mahmood.
54. The Panel asked Dr Gerada for her assistance on the use of the two drugs involved in this case. As to IV Diazepam she said:

> "I am led to believe Dr Mahmood used it as a sedative. I have not injected joints – my partners do and they do not use Diazepam IV. I know of nobody who does. I cannot think of any circumstances in general medical services, as opposed to enhanced services, to give it. Since 1991 when I qualified as GP I have never known of it. I am still puzzled as to what has happened to these IV diazepam vials. He tells me he has particular skills at joint injection and he tells me that the drugs cabinet was not securely locked. I do not know of any reason why an ordinary GP would use IV Diazepam."

55. She later told us that Dr Mahmood had told her that 24 vials of Diazepam were missing.
56. As for dihydrocodeine, only 1 of the doctors she had treated was a suspended user of dihydrocodeine. It was not much abused. It was a weak opiate and relatively easy to control. There was no reason why the prognosis for staying abstinent should not be at least as good as the 80% recovery rate for addict practitioners generally.
57. We asked Dr Gerada about the element of her appraisal which deals with probity. She said her appraisal gave her no concerns on this score. She knew there were adverse findings of dishonest prescribing but that was there forever and we had to move forward. The failure of record keeping was a learning issue. She agreed that her understanding of the FTPP findings was based on what Dr Mahmood had told her. She later told us that she had not seen the FTPP decision until today. She did not seem to

have been made aware of the dishonest findings (and indeed admissions) arising from the diazepam episode, nor in the attempt to cover up the dihydrocodeine episode. She also told us that her view of Dr Mahmood's strengths (such as there being no complaints from patients) was based on her conversations with him.

58. We asked Dr Gerada about the efficacy of the urine and hair testing and she told us that it could not pick up whether the patient was exceeding the prescribed dose of tramadol. She said you simply had to trust him and look for other signs such as missing or being late for appointments, chaotic life, and the surrounding circumstances.
59. We asked Dr Gerada about the final explanation given by Dr Mahmood for the missing vials of diazepam (all actually administered to patients but not recorded in the notes). She said it was not for her to judge his explanation, but it was reasonable to suppose he had not recorded giving these injections and also the cabinet was not very secure (he had told her).
60. Finally we asked Dr Gerada about the basis for regarding Dr Mahmood as an addict misusing dihydrocodeine; what was the evidence for that supposition? She told us: "It is true I just assumed he was abusing dihydrocodeine. There is no evidence he was in fact abusing it. There is no evidence that his GP was denying him the prescribed pain-controlling dose. It is sometimes diverted to the street. You would have to know your dealer. Diversion of dihydrocodeine is a problem in Scotland because heroine scarcer there, but not a prevalent problem in England."
61. Mr Colin indicated initially he did not propose to call Dr Mahmood but after taking instructions over the lunch adjournment Dr Mahmood gave evidence to us.
62. Dr Mahmood gave us his career background outlined above and explained that prior to working at Tollgate he had mostly worked as a salaried doctor at a practice at Addison Road, Walthamstow. He was then asked about the vials of diazepam which he had produced to replace those which were missing [R43] and he told us that these were his own stock from his own doctor's bag. He had bought them from a chemist as part of his own emergency stock and had given the name of the chemist to the PCT during its investigation. He agreed he had given 5 different explanations because "this was the first time I realised my mistakes and it was a terrible shock and I panicked. This was the first time since1999 with no complaint". He accepted they were misleading and untrue, and that was wrong. He described this conduct as a basic fundamental failure.
63. Dr Mahmood was asked about his signed statement of February 2007 in which he stated he had administered injectable diazepam to a number of Tollgate patients but had not recorded doing so in the patient records [see R44]. He said "I administered injectable diazepam because when I last worked in hospital in an A & E department these injections were frequently used. I had no previously seen injections available [in GP practices], and now saw them available in Tollgate. I thought therefore that these were available – I was wrong because there is a big difference between

emergency medicine and primary care." He said he had used injectable diazepam before in the hospital context.

64. Dr Mahmood denied that he was using injectable diazepam for himself or diverting it for his own gain.
65. He said he had not recorded the use of diazepam injections because the software used at Tollgate Centre was new to him and it was noted he needed training sessions. He conceded this was not an excuse. He also suggested there was time pressure at that practice for seeing patients and therefore recording secondary as well as primary treatment was time consuming, inputting the relevant codes. He agreed with Mr Colin, however, that record keeping was part of patient management and that in the absence of a record, doctors subsequently looking at the record would not know what medication had been given. He agreed this amounted to mismanagement. He said he could and should have improved his software knowledge and improved his time management.
66. Mr Colin raised with him one use of the diazepam put forward by Dr Mahmood, namely administering it to his brother who was a patient of another practice. He said he had been called by his brother who could not get to see his own GP and he told him he would give him the diazepam to relax muscle spasms. He now recognised this was a serious error as it was not normal practice to administer diazepam in a primary care setting unless it was one of a limited number of emergency situations.
67. He told us he had never disputed that he had made mistakes and must now move forward and he regarded that as being in the interests of patients also.
68. Dr Mahmood told us that after Tollgate he felt guilty and also under pressure. He was not working. He got into financial problems and developed depression. He had 3 children and was the only earner in the family. He knew about dihydrocodeine because he had been prescribed it since1998-9 for low back pain. He decided to see if it would help lift his mood and get rid of his suicidal thoughts. He had not sought help because he did not appreciate he should get help from his own doctor. The dihydrocodeine he prescribed in the name of QA was for his own use.
69. Dr Mahmood said he realised he had made mistakes before anyone noted it and contacted the Sick Doctors Trust. He knew he had misused dihydrocodeine and got his own GP to refer him to a Pain Clinic. He also asked his GP to replace dihydrocodeine with something else, and was now on tramadol for pain relief.
70. Dr Mahmood assured us that he had worked on his insight right from the start. He said "I looked everywhere and knocked on doors". He said he had sincere regrets and knew the mistakes he had made. He had looked at all the trigger factors and was now confident he was on the right path. He outlines further the history of his steps to address what he suggested was a drug rehabilitation problem, and stressed he remained willing to be tested. However he also asserted that he had never misused prescriptions to increase his dosage of dihydrocodeine until after his time at Tollgate.

71. Dr Mahmood told Mr Barnes that he had started work at Tollgate on 14 August and that the first stock take took place on 15 November 2006. He had not used injectable diazepam before arriving at Tollgate. It was not available in his previous GP practices. He was asked how many patients he had given it to. He said possibly 4 patients. One was an old lady who had arthritis and needed an injection in her knee, so one was used the first time and then a week later when she returned to have the other knee injected. One was a young man who had epilepsy [we noted that one indication in the BNF for using diazepam was status epilepticus, but Dr Mahmood did not suggest that acute emergency was the indication for administering it here]. One other lady was hyperventilating with acute anxiety. He thought he had used possibly 5 vials of diazepam on patients, altogether. He alleged he had noted after a while that his colleagues in this practice also had diazepam supplies in their own bags, so he bought his own pack of 10 from a chemist, and in due course handed over 9 of these to the Tollgate practice when challenged about the missing vials. The 10th had been used on his brother.
72. Mr Barnes then drew Dr Mahmood's attention to the account recorded by Dr Checinski (given by him) that 23 vials were found to be missing at Tollgate. Dr Mahmood said: "I see he recounts that 23 vials went missing and I have no reason to doubt that. I can't comment on whether other people had access and took vials without accounting for them. I cannot say anybody else was involved. I accept responsibility for 5 vials."
73. Dr Mahmood was then asked about his unfamiliarity with use of injectable diazepam in GP practice. He said he had not looked at the BNF [A27] before using it on patients and if he had he would have realised it was inappropriate. He explained (so far as we are aware, for the first time) that he had not administered the full 10 mg in each vial, but only 2 mg as a muscle relaxant.
74. Dr Mahmood said he was not aware of any other note-keeping failures for which he was responsible at Tollgate, other than the failure to record this use of injectable diazepam.
75. An additional new element of Dr Mahmood's account emerged when he was asked how he had obtained diazepam at the Tollgate practice. He said that he had asked a nurse for it and she had brought him a whole box of 10 vials when he was expecting only one vial, and at the end of the day "I just cleared it into my bag". When he had returned a box he thought this was the Tollgate practice box but in fact it was his own, bought from the chemist, and this was a mistake. Several weeks later the Tollgate practice told him the vials he had handed over were a different batch number.
76. Dr Mahmood was asked why he was panicking when he was asked about the missing vials, when on his account he had administered the only 5 for which he was responsible to patients in good faith, and his only error was in failing to record that. He said he panicked because he realised that diazepam was not acceptable treatment. He discovered this because he

had asked colleagues how often they used it and for what indications. Only then did he realise it was not to be used as he had done.

77. It was put to Dr Mahmood that three of the oral explanations given to investigators (diazepam may have been given to patients but not recorded and also that diazepam had been administered to his brother, and lastly that he had used diazepam in dribs and drabs for different patients) had been admitted by him as being misleading during proceedings before the FTPP [see R44; para 9] when in fact he was now suggesting all three were true. He agreed that was the case except that the diazepam given to his brother had come from his own stock and not from the Tollgate stock. He insisted that the explanation he was giving today was correct.
78. Dr Mahmood agreed that Dr Gerada recalled he had been able to tell her about one patient to whom he had given diazepam whereas he was telling us today about 3 patients whom he could remember. He said that he was taking responsibility for 5 of the 23 missing vials and denied (when it was put to him) that he was responsible for all 23. He also denied that he had panicked because he knew he was responsible for all 23 vials found missing.
79. Dr Mahmood's claim to have achieved insight into his failings was challenged. His attention was drawn to the accounts and explanations that he had given to three doctors, as appeared from the accounts they had recorded in the medical reports which he had placed in the Respondent's bundle.
80. Firstly, Dr Checinsky at R7, second paragraph of his report dated 24 March 2009, recorded under the heading "Index event":

    > "After some uncertainty over the exact numbers, there were found to be twenty three 10 mg diazepam vials missing. Dr Mahmood describes this as occurring through his poor record-keeping and asserts he did not use any of it for himself."

    When Mr Barnes put it to Dr Mahmood that that was not the full extent of his failings, but he was not prepared to own up to more, Dr Mahmood explained that this had been a long interview and that he had told Dr Checinsky that he had not recorded the use of the diazepam "because of those silly reasons [previously given in evidence to the Panel]".
81. Secondly it was put to him that he showed a similar failure to acknowledge his wrongdoing in full when he gave the account to Dr Savla which is recorded in his report dated 6 April 2009 and appears at R14:

    > "Dr Mahmood stated that there was an issue of missing prescriptions of diazepam injections on 3 different patients, which he has not documented….He stated that whiles he has used the injections on the patients, he had not made a proper record of injection given. He denied using the injections on himself or sold it for purpose of financial gain."

    Again, Dr Mahmood said that it was not really fair to criticise him for this because it was a summary of a long interview.

82. Thirdly, his attention was drawn to the letter dated 5 November 2008 from Dr Basquille, his treating Consultant [R23] in which he recorded that Dr Mahmood was placed under restriction for 2 main reasons:

> "(1) The first was for inadequate record keeping…. (2) He was suspended by the GMC for misuse of DF118, a controlled drug."

It was suggested to him that it was only today that he had attempted to confront the other issues around the diazepam prescriptions, especially whether he should have given this drug at all to his patients. There was also the matter of the false or misleading explanations to investigators. Dr Mahmood did not appear to follow this suggestion.

83. Lastly Mr Barnes put to Dr Mahmood the GMC findings set out at the foot of page R51 going over to R52. He respected and accepted the GMC findings: these included dishonesty in completing prescriptions ostensibly for a patient, QA, and then presenting them for his own use, and his misconduct in subsequently stopping of cancelling the computer record of some of those prescriptions, and untruthfully and misleadingly claiming that a prescription he had presented was a private prescription and therefore would not be recorded. These findings included that his dishonest actions started on the first day he had been employed as a locum at that practice. Dr Mahmood said that there were about 6 prescriptions in all, and that he had used two, "and they were deleted. They were not all used because I stopped myself at the last minute. I deleted them and it is not standard. I accept being dishonest in these issues."
84. The Panel asked Dr Mahmood about his earlier career and acquaintance with the procedure of injecting joints. He said he had had no training in joint injection. He had had sessions in a rheumatology clinic for about 2 weeks, on 2 or 3 days a week: about 10 clinics in all. He said he would not have seen a lot of joint injections during that period, probably about 4 cases. He had not performed any himself under supervision. But as part of his general medicine training he had injected steroids into joints and drained joint effusions. He had learned from the senior doctors on the ward and had probably seen about 10 -15 joint injections and done a further 10 himself during that training placement. In 4 or 5 of these cases he had seen doctors give Diazepam injections prior to injecting the joint. He had attended a course on minor surgery, but admitted that it did not cover joint injections. Nobody advised him you should give Diazepam injections in this situation but he had not been told you should not do so. Prior to joining Tollgate he thought he might have performed between 5 and 7 joint injections over 2 ½ years.
85. Dr Mahmood admitted he had "not bothered" to put himself on the minor surgery list, although he agreed that he would then have been able to claim payments for performing this kind of minor surgery. He explained he just did it for patients who "turned up". Nobody had suggested he should refer the patient to another doctor who was on the minor surgery list and could therefore claim payment, nor did he think of it himself.

86. As for his unfamiliarity with the computer system at Tollgate, he said his training practice had used the Vision system and Tollgate used EMIS. He had in fact used EMIS since completion of his training in the various practices (5 or 6) where he had performed locum GP sessions around East London. He agreed that he pressed a button to issue a prescription.
87. Dr Mahmood told us that when he was a locum he either took medication from the practice or made out a prescription to the patient. However in August 2006 he had started as a “proper GP” in two practices about 3 miles apart and decided to keep some medicines in a bag, for use in emergency, such as IV adrenaline, painkillers such as diclofenac (but not opiates) Maxolon and Stematil. He had acquired Diazepam to add to his emergency medication in his bag. He had bought it from a chemist by issuing a private prescription on surgery headed paper. It was a box of 10 vials each containing 10 mg. He only ever used 2 mg from a vial, but had not purchased smaller vials, although this would have been convenient. He had not obtained a receipt from the chemist as he did not think it worth bothering. This was the only occasion he had bought drugs.
88. We asked Dr Mahmood about the Tollgate Practice. He said he and another employed doctor had started with a zero list, built it up to 1000 patients while he was working there and by the time he left it was about 2000 patients. He agreed this was not a big list. He told us that the healthcare assistant was responsible for all stocks of medication and he did not know where he got them from. He said “I would just ask him or one of the nurses for Diazepam. I was not asked to sign for it. There was no paper record”. He accepted there was no record of any in-house transaction. He told us that when he had used Diazepam on patients he had not recorded doing so in the consultation note or prescription record used on the Tollgate software system. When asked why he did not type in Diazepam 10 mg he said “I just became lazy”.
89. We asked about the explanation that Dr Mahmood had previously given us, that he was very pressed for time in meeting practice guidelines for patient management, and asked him whether it was more cumbersome and time consuming to give a patient a preliminary injection of Diazepam before the joint injection. He told us that he had a patient who was extremely tense and he could not inject the joint so decided to give Diazepam. He had not recorded it. Another occasion concerned a young man who was suffering phenytoin toxicity and Dr Mahmood referred him to a neurologist. He said he was “not fitting but was starting to shake, and I thought he was about to fit, so I gave him a small dose of Diazepam”.
90. When we asked Dr Mahmood to help us further with regard to the Dihydrocodeine episode, he told us that QA was a general patient of the practice [we noted that the admitted FTTP findings were that Dr Mahmood brought him to the practice and asked that he be registered], and asserted that the first prescription for Dihydrocodeine was properly issued on the computer for a road traffic accident. This suggestion had not previously appeared in the papers or his previous evidence to us. Dr Mahmood said

that on the second occasion and subsequently he issued prescriptions in QA's name when QA had no such need. He said one private prescription was also issued. He had generated that on the computer too. The chemist rang the Practice who informed her there was no record of the prescription and she therefore did not issue the medication. Dr Mahmood further explained that QA was a temporary patient and that he deleted the record of prescribing but the patient's records would now be incorrect. We understood this to be a reference to the fact that consultation records (and any reference to drugs prescribed in the consultation record) cannot be deleted.

91. Dr Mahmood was asked what lessons he thought he had learned through this experience. He said every day was a serious regret and he had had no previous incidents, but did not identify out what lessons he had in fact learned.
92. Dr Mahmood agreed that so far as the dihydrocodeine was concerned it was not a record-keeping issue in the sense of a negligent failure to record, since he had deliberately and dishonestly tried not to leave a record.
93. Dr Mahmood was asked what strategies he had learned or adopted so far as his future conduct was concerned. He said he had asked his doctor to take him off dihydrocodeine, and refer him to a Pain Clinic, and he was now on prescribed doses of Tramadol.
94. He told us that he thought it was OK to give Diazepam to his patients at the time he did it, but not later, after he had asked the opinion of colleagues at the time that the problem with the stock was raised. He had discussed it, he said, with 4 or 5 other medical colleagues, but not the other employed GP at Tollgate, whom he hardly ever saw. He said he had accepted responsibility for some of the missing vials and when the Tollgate Practice had asked him he told them he had used them on patients, then when the Practice Manager asked to look at his records he "realised [he] had not recorded them".
95. As for the dihydrocodeine, Dr Mahmood told us that he had suffered joint pain since 1998/9, and was treated by his GP who prescribed diclofenac and subsequently dihydrocodeine. He was still being prescribed dihydrocodeine at the time he made out the [bogus] prescriptions for that drug, but had not asked his own GP for an increased dose.

<u>Submissions</u>

96. We received submissions from Counsel from both parties, which we do not set out in detail, but the submissions included the following points.
97. For the PCT, Mr Barnes submitted, among other things:
    a. Diazepam:
        i. Patient safety. The PCT did not accept Dr Mahmood's account as given in his Feb 1998 statement, but on the face of his statement he had failed to note administering Diazepam to 5 patients.

ii. Dr Mahmood says he injected on 5 occasions on basis of his experience of experience in hospital medicine and without consulting colleagues or the BNF. This was a dangerous approach and also gave concerns about patient safety.
iii. Where did 23 vials of Diazepam go and is his explanation to be accepted? Only 5 were accounted for by Dr Mahmood. He is unable to offer any explanation where the others went.
iv. He made no record of administering Diazepam in any of the cases which he subsequently put forward to account for their use – missing all 5 of them is extremely telling. If the failure to record was limited only to Diazepam but not to other treatment (and there was no suggestion that other treatment had not been recorded) then that is something which causes concern.
v. Dr Mahmood started using Diazepam very suddenly on at least 5 occasions and that includes purchasing 10 vials for his bag.
vi. He says he was shocked when his use of Diazepam came to light, and therefore misled the investigators. If the truth is that he was simply prescribing according to what he thought was the right approach, he had no reasonable cause for alarm. The FTPP found it difficult to accept the explanation and the PCT submitted it should not be accepted.
vii. There was dishonesty in relation to the Diazepam, including his attempt to reintroduce 9 vials into the Tollgate Practice from somewhere else, and his misleading explanations given during the investigation. There were serious concerns as to his honesty. In all likelihood Dr Mahmood is responsible for the missing 23 vials. Mr Barnes also relied on the evidence of Dr Gerada that Dr Mahmood had told her about only one patient whom he had injected with Diazepam.
viii. There was no question of any mental health disorder affecting Dr Mahmood's conduct during the Diazepam episode.

b. Dihydrocodeine:
i. Mr Barnes submitted that Dr Mahmood accepted his dishonesty and the calculated nature of it.
ii. Why did he not seek help, which was available as he was under treatment for pain control from his GP?
iii. Dr Gerada's assumption that he was dealing with withdrawal was not supported by the evidence.
iv. Dr Mahmood was effectively on a warning when he embarked on issuing these bogus prescriptions, since he was already on conditions imposed by the GMC, arising out of the Diazepam episode. Yet he still went ahead and abused the opportunity to issue prescriptions.

v. The medical reports did not excuse his actions.
vi. He showed little insight. Mr Barnes referred to the answers given above. He submitted that to describe the use of dihydrocodeine as a genuine mistake did not show a proper understanding of what went wrong and the steps he might need to take to avoid it happening again.

c. Mr Barnes submitted that these were two unrelated episode, each involving calculated and persistent misconduct. Each showed an attempt at concealment and an approach to patient safety in relation to prescribing drugs, which was unacceptable.
d. He invited us to balance this against Dr Mahmood's previous clean record, but pointed out that he had produced no professional references or appraisals.
e. Anticipating a submission from Mr Colin, Mr Barnes submitted that the conditions attached Dr Mahmood's registration by the FTPP of the GMC would impose an unacceptable burden on a PCT, considering the concerns identified, and would be difficult to arrange in practice.

98. Mr Colin submitted that:
a. This was not a case for National Disqualification having regard to the evidence of Dr Gerada and Department of Health Guidance (see above). Workable and enforceable conditions had been formulated by the FTPP of the GMC to safeguard the public interest and the doctor's interests.
b. The sanction of 3 months suspension reflected the view taken by the FTPP as to the seriousness of the misconduct.
c. The explanation given by Dr Mahmood had not altered from that given to the GMC. He had accepted all the FTPP findings and had made admissions to the FTPP from the outset: he took us to the multiple admissions of being misleading, inappropriate, and so on. He submitted that he had also admitted impairment of his fitness to practise, and said that this demonstrated his insight. Nevertheless the PCT's position was predicated on the basis that discipline must always be looking backwards. Insight was also demonstrated by the way he had given evidence and his steps to seek rehabilitation and remediation.
d. He recognised we were not bound by the FTPP conclusions but we were considering the same things, particularly in relation to the public interest. He conceded that the FTPP findings and doubting of Dr Mahmood's credibility had a deleterious effect on Dr Mahmood's case. He went so far as to concede that this was an impossible position to maintain. He drew our attention to one of the FTPP findings accepted by Dr Mahmood (at R52) to the effect that at the time of issuing the dishonest prescriptions for dihydrocodeine, opioid dependence was not the driving force behind Dr Mahmood's actions.

e. However, Mr Colin relied on the medical reports from Dr Checinski, Dr Basquille and others to show that Dr Mahmood had availed himself of the help offered and the prognosis was good.
f. Mr Colin took us to a number of other findings of the FTPP, including at R34 (part of the decision on the review conducted on 5 May 2009), that there was no evidence of dishonesty prior to the incident in which he altered the clinical records [we presume this refers to his attempted cover up of the bogus prescriptions for dihydrocodeine], nor any repetition since. He made the point that *at that date* the FTPP did not find that Dr Mahmood's fitness to practise was impaired by reason of misconduct, but was impaired by reason of his adverse health.
g. He invited us to find there were no harmful deep seated problems and that such a finding was supported by the evidence of Dr Gerada. In all the circumstances it was not appropriate to impose National Disqualification, which would have the effect of punishing the doctor for an additional 2 year period.
h. Mr Colin did not expressly address us on the issue of the 2 year period but it was perfectly clear that in light of his submissions on National Disqualification he opposed any possible extension.

Consideration and decision

99. The misconduct giving rise to this application raises serious issues of probity and of patient welfare. On his own admissions, Dr Mahmood used injectable diazepam inappropriately and without any training in its use or reference to standard readily available publications, failed to record treatment given to any of the patients he said he used it on, gave untrue or misleading explanations to investigators to account for missing drug stock, `and attempted to replace 9 vials of diazepam which he said he had been carrying in his bag, which proved not to be from the Tollgate drug stock, but had been acquired elsewhere. Subsequently and while under investigation by the GMC for this conduct, he took virtually the first opportunity he had in a new practice to generate a series of bogus prescriptions for dihydrocodeine, falsely pretending they were for the genuine needs of a patient, when in fact he intended to present and use them himself. When challenged about the lack of a record of the issue of a prescription to QA on 19 November 2007, he falsely asserted that it was a private prescription and there would therefore be no record (conduct which the FTPP found "particularly serious"). He also attempted to conceal the fact that he had issued these prescriptions by stopping or cancelling a number of them. He admitted to us that the patient's records would be misleading.

100. The admitted misconduct is not in its nature essentially local to the area where the practitioner was working, and Mr Colin did not attempt to argue otherwise.

101. Thus the factors set out in the Department of Health Guidance [see paragraphs 10 and11 above] are engaged.

102. It is not possible to view the criticised conduct as a one-off lapse. It spans several months. Each period of misconduct (Tollgate and Becontree) contained multiple examples of dishonest or misleading conduct. Each began near or (in the case of Becontree) at the very beginning of being in post and having the opportunity to do so. The Becontree misconduct occurred while under investigation and subject to interim conditions for the Tollgate episode.

103. The range of misconduct, on Dr Mahmood's own account, is also significant. It involves disregard for patient welfare in a number of respects, including inappropriate administration of diazepam, without adequate indication for such treatment, training in doing so, or troubling to check with the BNF, a book by the elbow of every doctor, and failure to record the treatment given in any of the cases to which he admits. Patient welfare is also adversely affected by his conduct at Becontree in cancelling prescriptions in the name of QA while part of the computer record continued to show he had received this opiate, so producing a misleading medical record. It also involves dishonesty. When he was challenged at both GP practices, he produced misleading or dishonest explanations in an attempt to avoid detection. At Becontree, his issuing of bogus prescriptions with a view to obtaining and abusing dihydrocodeine himself was a dishonest enterprise from the outset, and an abuse of NHS resources.

104. However, Mr Colin points to Dr Mahmood's early admissions to the FTPP of wrongdoing and impaired fitness to practise and invites us to conclude that there are no deep seated problems and that the public interest is now sufficiently protected. We have asked ourselves whether we were satisfied that Dr Mahmood has made a clean breast of his wrongdoing, has shown insight into the mischief of his actions, their effect on patients and the effective operation of NHS resources and working arrangements, and is unlikely to repeat this or similar misconduct. We have therefore given careful consideration to the explanations put forward by Dr Mahmood, pursuant to our view of the relevant factors set out at paragraph 11 above. If it were the case, for example, that Dr Mahmood was not being truthful or candid in his account and explanations to us, it would have a considerable bearing on whether it was appropriate to impose National Disqualification.

105. With considerable regret, we feel driven to the conclusion that we are unable to accept that Dr Mahmood has given us a full, frank and honest explanation for what occurred.

106. We have taken into account the impression he made as a witness, making all allowances for his professional discomfort at addressing these issues, any nervousness and the fact that English is not his first language (albeit he has studied and worked in the UK since 1994 and satisfied the examiners in the PLEB). We found him to be unconvincing in manner. He appeared not to address the difficult questions head on, instead giving answers which were either trite or avoided the point (eg paragraph 91

above). Some of his account appeared to be new and gave the impression of being produced to deal with a difficult new question. This is not to say that Dr Mahmood is not deeply regretful about the position he finds himself in.

107. We refer to paragraphs 19, 20 and 21 above, and agree with the observations of the FTPP there recorded, and which Dr Mahmood expressly accepts. In our view it is a necessary inference from the conclusion that these three separate explanations were unacceptable, that Dr Mahmood was not telling the truth when he offered them.

108. Dr Mahmood could offer no plausible explanations of why he had given misleading statements about the missing diazepam vials (see paragraph 19). He gave us a new explanation or gloss that he had only administered about 2 mg to each patient out of the 10 mg vials he used (see paragraph 73) and also that he had just asked a nurse to bring him diazepam and she unexpectedly brought him a whole box of 10 vials which at the end of the day “I just cleared into my bag” (see paragraph 75). He went on to claim that when he returned a box of vials to the Tollgate practice, he mistakenly thought it was their box, but in fact it was one he had bought himself from the chemist. In our judgement this account is not credible. It also raises the question of what happened to the remaining 9 vials in the Tollgate box of diazepam (taking his account as factually correct for the moment), given that he returned 9 from elsewhere, and admits only to using 5 vials on patients in the practice (see paragraph 71).

109. We are also unable to accept, on a balance of probabilities, that Dr Mahmood failed in any of the 5 cases he says he did this, to record the administration of injectable diazepam, on account of pressure of time or unfamiliarity with the computer system. It is telling that it was not just one omission to record, but happened in all 5 of the treatments which should provide proof of his explanation. We also share the view of the FTPP that it is inexplicable that Dr Mahmood failed to record the secondary treatment but was capable of recording the primary treatment for these patients. We are satisfied that he was familiar with the (relatively commonplace) computer system used by Tollgate, from his work as a locum elsewhere, and had not made any other errors or omissions which have been brought to our attention. He knew how to record consultations and record prescriptions and treatments, and did so. There was no special magic about recording the injection of diazepam, if he had done so. Nor did we find convincing Dr Mahmood’s new or further account of administering diazepam to a patient who he thought might be about to start fitting, which seemed to be produced in response to a question in cross-examination (see para 71). We also note that in this single case the administration of diazepam was not secondary to some other treatment, so that explanation for his failure to record it cannot apply.

110. Some additional “new” elements of Dr Mahmood’s evidence to us were that he only used about 2 mg of each 10 mg vial of diazepam when

he used it as secondary treatment to relax the patient's muscles before injecting the joint, when he agreed it would have been much more convenient to purchase 2 mg vials (see para 87) and that he had not recorded the use of diazepam in the consultation note or prescription record because "I just became lazy".

111. The evidence that 23 vials of diazepam had gone missing, in total, came from Dr Mahmood's own account recorded in the report of Dr Checinski (R7). Dr Mahmood said "I have no reason to doubt that. I can't comment on whether other people had access and took vials without accounting for them…I accept responsibility for 5 vials". Logically, the other 17 vials could only have been taken by other people, without recording the fact. This presumes either a lax stock control system (about which we have no evidence) or dishonesty by others, or both. It also presumes a level of use of injectable diazepam in a GP practice which is far in excess of anything which would ordinarily be expected in competent practice, on the evidence available to us. We are unable to accept this. In our judgement it is likely that Dr Mahmood was responsible for all the missing vials and has been unable to advance a credible explanation for what has happened to them.

112. The explanation offered in respect of the 5 vials (at least since February 2007) necessarily involves Dr Mahmood using injectable diazepam in clinical situations for the very first time, quite suddenly, and on relatively frequent occasions, given the rarity of its appropriate use. He says this was because diazepam was available at Tollgate but not at other practices where he had worked. But he could not have seen it used in this clinical situation, nor been instructed or advised to do so. The only exposure he had had to the secondary use of diazepam was in the very different clinical situation described at paragraph 84 above. Moreover there is no good reason why he would not have put himself on the minor surgery list if performing this kind of procedure, so that he could claim the appropriate payment for it. He did not do so.

113. It is instructive to look at Dr Mahmood's response when he was taxed with the missing diazepam vials after the stock-take. In our view Mr Barnes' point is well made, that there was no need to panic and tell lies about what had happened to the vials, if in truth Dr Mahmood knew that his only sin was to have failed to record their use properly. He could have said that and apologised, and in the course of doing so helped to identify the patients whose records were now incomplete. He has not identified these patients to us, nor (so far as we know from his evidence) to the Tollgate practice or the PCT. Instead he concocted a number of explanations, one of which pointed a finger of blame elsewhere. In our view his subsequent conduct is much more consistent with the panic of a man who knew he would be unable to account satisfactorily for a number of vials of diazepam which he had taken but not administered to patients for bona fide therapeutic reasons.

114. In respect of the events at Tollgate and Dr Mahmood's subsequent conduct relating to the missing vials of diazepam, there can be no question of drug dependency or depression playing any part in that. The medical reports, insofar as they diagnose an episode of depression, identify its cause to be the consequences of the Tollgate events. To that extent the medical evidence is irrelevant to our consideration of that part of the case.

115. Overarching all these factors is the fact that Dr Mahmood accepts the decision of the FTPP in its entirety. We do not find it surprising that Mr Colin characterised the deleterious effect of the FTPP findings (in particular as set out at paras 19-21 above) on Dr Mahmood's credibility as "an impossible position to maintain". Looking at Dr Mahmood's account as a whole, and scrutinising his various explanations, we are unable to accept that he used the injectable diazepam in the way he has told us in evidence or that he was responsible for only 5 of the missing vials.

116. We are unable to speculate on what did in fact happen to the diazepam which remains unaccounted for. For present purposes we can only conclude that Dr Mahmood has not been candid in his evidence to us, by persisting in explanations that are untrue and incomplete. This conclusion undermines any claim he may have to have achieved insight and throws into doubt his trustworthiness. His want of insight is further demonstrated by the incomplete and misleading accounts of the extent of his wrongdoing which he gave to three psychiatrists who examined him and whose reports have been placed before us: see paragraphs 79 to 82 above.

117. In relation to the dihydrocodeine episode at Becontree, we agree with the FTPP (as does Dr Mahmood), set out at R52 3rd paragraph, that at the time of his dishonest prescribing, his judgement was not so seriously affected by his depression and opioid dependence that such dependence was the driving force behind his actions, and that he was aware that what he was doing was wrong, both with regard to the obtaining of prescriptions dishonestly and the attempts to cover up his actions.

118. We have received a good deal of medical evidence in this case, which has been presented by Dr Mahmood as a case of a man who suffered depression, slipped into opioid dependence, but has now recovered from both conditions, and demonstrated resolve in rehabilitating himself, with a good medical prognosis. We are not at all sure that the medical evidence is at the heart of this case; rather, there is a danger that it is a distraction. For the reasons set out at paragraph 114 above it has nothing to do with the Tollgate episode. We accept that he presented to his GP in July 2007 describing suicidal feelings, and was prescribed an anti-depressant. We further accept that various psychiatrists who examined him on behalf of the GMC diagnosed a moderate depressive episode, which had responded well and was (by March 2009) in remission.

119. However the diagnosis of opioid dependency (currently in remission and with a good prognosis) appears to rely entirely on Dr Mahmood's own account of abusing dihydrocodeine at around the time of his dishonest actions at Becontree to obtain pain relief where his current dose was proving inadequate, and to obtain mood-lifting benefits over and above pain relief. He has been extensively tested by blood, urine and hair analysis and the results are normal, subject to showing the presence of tramadol consistent with the prescribed amounts he should be having. We also note that on his own account he was only successful in obtaining additional dihydrocodeine on the bogus prescriptions on two occasions. He told us he had stopped or cancelled the other ones. Otherwise he was on a standard therapeutic dose of dihydrocodeine for pain control.

120. Dr Mahmood's account is hard to reconcile with the fact that he was being prescribed dihydrocodeine by his own GP but did not tell him that his pain was not being adequately controlled, or ask for a more effective dose. Had he done so, but been refused, his explanation of turning to dishonest means might be more understandable.

121. Dr Gerada told us: "It is true I just assumed he was abusing dihydrocodeine. There is no evidence he was in fact abusing it. There is no evidence that his GP was denying him the prescribed pain-controlling dose. It is sometimes diverted to the street. You would have to know your dealer. Diversion of dihydrocodeine is a problem in Scotland because heroine scarcer there, but not a prevalent problem in England."

122. Dr Gerada has impressive credentials. She is a dedicated and (we would judge) effective medical practitioner who is pioneering an important service for medical and dental practitioners affected by alcohol and drug dependency. We accept her evidence about the prognosis for recovering addicts in these professions. However, quite understandably she viewed Dr Mahmood through the prism of a substance misuse specialist. She was commendably supportive of Dr Mahmood as she no doubt is of all her patients. But when she reports "full insight into recent failings" (R59) and "was clear that he would never self-prescribe again", it seemed to us that her focus was exclusively on the Becontree events with their suggestion of misuse of opiates, and left out of account the dishonesty and other failings involved in the Tollgate events. It also became apparent that she had not seen the full GMC decision until the day of this hearing, and did not seem to have been made aware of the findings of dishonesty associated with Tollgate, or the attempt to cover up the Becontree episode (see paragraph 57 above). In our view the opinion she expresses as to probity is somewhat undermined by the fact that she has not had the benefit of access to all the evidence which is available to us.

123. We are concerned by the fact that Dr Mahmood's dishonest use of bogus prescriptions at Becontree happened at the earliest opportunity and appears to have been considered, in that he turned up with QA and required him to be registered as an urgent patient, before generating the bogus prescriptions for him. Dihydrocodeine is an opiate with possible but

not commonplace misuse potential. We share the FTPP's view that his dishonest attempt to cover up the use of false prescriptions by asserting that there was no computer record of the prescription issued on 19 November 2007 because it was a private prescription (see paragraph 24 above) was particularly serious. Dr Mahmood accepts this judgement. We were therefore puzzled that in his evidence to us he appeared to revive this explanation (see paragraph 90) and also raised for the first time a suggestion that the first prescription of dihydrocodeine had been a genuine one issued for good reason. It is difficult to reconcile this new assertion with his formal admission to the FTPP that 5 prescriptions were issued by him on 2nd to 24th November 2007 and were inappropriate and irresponsible, and those actions were dishonest (see R45-46).

124. In light of our conclusions generally about the reliability of Dr Mahmood's explanations, and the factors set out at paragraph 114 and following above, we are unable to be satisfied as to what happened to the dihydrocodeine which was the subject of the admittedly false prescriptions prepared by Dr Mahmood. We are simply left with the admitted dishonesty of issuing the bogus prescriptions, the admitted dishonesty of the attempted cover-up, and the admissions that a number of the prescriptions for dihydrocodeine were in fact for Dr Mahmood, together with the admissions of a failure to record the prescription issued on 19 November 2007 and the improper alteration of the records to stop or cancel some prescriptions so that QA's patient records were inaccurate.

125. In our judgement, therefore, the explanations offered by Dr Mahmood to us in evidence are untrue in material respects set out above. It is not possible to accept that such a practitioner has reflected on his conduct and confronted his failings. It is not possible to accept that he is now trustworthy, or that his dishonesty was confined to one discrete period of his professional life. Nor is it possible to conclude that his deficiencies in the area of probity will be remedied in the near to medium term.

126. Any PCT has a proper interest in relying on the probity of doctors on its Performers List. By virtue of being on the List, such doctors have access to a population of NHS patients, who place their trust in them. So also the PCT needs to have trust and confidence in the probity of the doctors with whom it deals on a variety of medical, organisational and financial matters.

127. There is also a range of deficiencies or misconduct with which we are concerned in this case, either on his own account, or as we have found. His admitted misconduct in 2006-7 involved wilful and persistent disregard of patient welfare in the administration of in appropriate drugs and the recording of drug treatment given or prescriptions issued, so that doctors who later treated the patients would be misled.

128. Lastly it is a necessary consequence of his conduct, either as admitted by him or found by us, that Dr Mahmood has misused NHS resources.

129. Balancing these findings against Dr Mahmood's proper interest in returning to practice, supporting his family and rebuilding his medical career, and the need to achieve proportionality, we conclude that it is necessary to grant the application for National Disqualification. But we do not consider it necessary to extend the normal period of two years before which Dr Mahmood can apply for a review of his National Disqualification.

130. In accordance with Rule 42 (5) of the Family Health Service Appeal Authority (Procedure) Rules 2001 the Appellant is hereby notified that he may have the right to appeal against this decision under Section 11 of the Tribunals and Inquiries Act 1992. Any appeal shall be made by lodging a notice of appeal in the Royal Courts of Justice, The Strand, London WC2A 2LL within 28 days from the receipt of this decision.

Signed 

Duncan Pratt
Chair of the Panel

Dated 14 September 2009