Recommendation 2: Prescribing Rights of Medical Practitioners (see Annex A for full text)

1. The licensing and revalidation guidance to doctors (issued for consultation in September 2004) makes it clear (paragraph 52) that from 1 April 2005 only licensed doctors will be able to exercise any of the privileges currently associated with prescribing, including the prescribing of controlled, or any other drugs. In order to retain a licence doctors will need to show, every five years, that they have been practising medicine in accordance with the principles set out in Good Medical Practice. These principles include requirements on doctors to maintain good medical practice by keeping their knowledge and skills up to date and maintaining their performance through participation in regular and systematic medical and clinical audit.

2. Council has also agreed revised guidance on prescribing medicines through the publication of Frequently Asked Questions on Prescribing Medicines (Council meeting, 15 September 2004). The following is an extract from that guidance:

‘Q2. What can you do to ensure that you prescribe safely?

1. In order to prescribe safely you must prescribe only within the limits of your competence. You must follow the advice in Good Medical Practice and be aware of the major contraindications and side effects of the drugs you prescribe.

Q3. What guidance does the GMC give on prescribing medicines?

1. Good Medical Practice sets out the principles of good practice and care that you are expected to meet. The advice below expands on these principles.

2. When prescribing medicines you must ensure that your prescribing is appropriate and responsible and in the patient’s best interests. To do this you must:

- Recognise and work within the limits of your professional competence.

- Ensure you are familiar with current guidance published in the British National Formulary, including the use, side effects and contraindications of the medicines that you prescribe. You should be aware of the guidelines about the clinical and cost-effectiveness of interventions published by the National Institute for Clinical Excellence (NICE) in England & Wales and in Scotland by the Scottish Intercollegiate Guidelines Network (SIGN). In addition the Department of Health has published a report Building a Safer NHS: Improving Medication Safety on the safe use and administration of medicines. For website addresses of these organisations see Q11.’
3. The Standards and Ethics Committee will be reviewing the guidance on prescribing medicines, and reviewing *Good Medical Practice* (following a consultation process), with a view to examining whether the guidance can be further strengthened in the light of the Inquiry’s recommendation.

**Recommendation 3: Self-prescribing/self-administration by a doctor of a controlled drug for him/herself (see Annex A for full text)**

4. When the Standards and Ethics Committee considered this recommendation (meeting 21 September 2004) they noted that it has always been regarded as inappropriate by the GMC for doctors to prescribe controlled drugs for themselves or their families. The Committee’s view, in the light of the Report, is that our guidance should be strengthened to indicate that doctors should not prescribe or self-administer a controlled drug, or indeed to do so for their family or friends, other than in an emergency. Guidance may be needed on the interpretation of ‘emergency’ and ‘family’. We have made it clear that we expect doctors to comply with the standards of good practice set out in our guidance, and that a doctor must be prepared to explain and justify any decision not to follow the advice on good practice in prescribing.

5. If prescribing of this kind were made a criminal offence, it would entail a change to primary legislation. Leaving aside how quickly that could be achieved, there is a risk that, if implemented, putting this on a criminal basis may deter those with addiction problems from seeking help. While it is of course a matter for the Government, there is thus a danger that the creation of a new criminal offence could have unintended consequences. While fully supportive of the spirit of the recommendation, the objective could be better achieved through strengthened GMC guidance, rigorously enforced.

**Recommendation 4: Prescribing of controlled drugs to family members on a GP’s list (see Annex A for full text)**

6. The Standards and Ethics Committee decided, at their meeting in September 2004 to draft a statement, for approval by Council, explaining why it is unacceptable for doctors to prescribe controlled drugs for themselves, family or friends. This will of course be subject to a process of prior consultation. The outcome would be published in *GMC News* and on our website, and its inclusion could also be considered in the next edition of *Good Medical Practice*, if appropriate.

7. We understand that the Government recognise that this recommendation raises particular issues for doctors and their families in small rural communities that will need to be addressed as the guidance is developed. Other doctors working in isolated areas or practices may also be affected, for example, some military doctors, and we will ensure these issues are considered with regard to all the different groups potentially affected.
Recommendation 5: Prescribing controlled drugs outside a genuine professional relationship (see Annex A for full text)

8. While noting some difficulties in the phrasing of this recommendation, the Standards and Ethics Committee supported its overall intention and endorsed the need to clarify our current guidance. The guidance will be reviewed as set out in paragraph 6 above.

Recommendation 6: Duty on doctors to report convictions/cautions involving controlled drugs (see Annex A for full text)

9. In September 2004, Council discussed the issue of a doctors’ responsibility to report to the GMC when criminal or disciplinary action had been taken against them or was in prospect. Council agreed:

a. To place a duty on doctors to inform the GMC when they are the subject of criminal proceedings or have findings made against them by other regulatory bodies.

b. That, except in respect of minor motoring offences relating to speeding and parking (provided that such offences do not involve driving under the influence of alcohol or drugs, or raise questions of honesty), doctors must inform the GMC promptly if they:

   i. Accept a police caution.
   
   ii. Are charged with any criminal offence.
   
   iii. Are convicted of any criminal offence anywhere in the world.

   iv. Have had their registration restricted, or been found guilty of an offence by another regulatory body, in the UK or elsewhere.

   c. That the duty on doctors to inform the GMC if they are subject to criminal proceedings, or have had their registration affected by another regulatory body, should be included in the next edition of Good Medical Practice. In addition, a statement about this obligation should be included in the next edition of GMC News and publicised on our website. It should be made clear that failure to comply may raise questions about a doctor’s registration. Doctors should seek advice from the GMC or a defence body if they are unsure whether to make a report.

10. The Standards and Ethics Committee have agreed to prepare draft guidance on doctors’ duty to report involvement in criminal and regulatory proceedings, and expect to start a consultation process to take this issue forward in the near future. Council’s decision in September 2004 was that where the need arises doctors must report the matter to the GMC ‘promptly’, although further consideration may need to be given to specifying a particular timescale.
11. When information about criminal proceedings involving controlled drugs (or other serious offences) was received by the GMC we would, as a matter of course, consider whether interim action was necessary, and would inform anyone of whom we are aware the doctor is employed to provide services, or to anyone we consider it is in the public interest to disclose to, as provided for by section 35B of the Medical Act 1983.

**Recommendation 7: Need for independent review and audit of use by GMC and PCTs of powers to restrict the practice of doctors involved in controlled drugs offences (see Annex A for full text)**

12. The FPC has established a process to enable audit of decisions made by Fitness to Practise panels (through the Determination Audit Sub-Group established in December 2003) and of decisions at the investigation stage (through the Investigation Audit Sub-Group). In addition, we have started to publish case studies (anonymised) on our website which highlight issues arising from fitness to practise hearings, as a way of raising awareness about important aspects of our guidance and to encourage learning.

13. In addition, the GMC's Health Review Group is undertaking a review of the health procedures, and as part of this review, will be considering information about the number and characteristics of doctors referred into the procedures. The Group's terms of reference include looking at implications of evidence presented to/conclusions reached by the Shipman Inquiry. The Group will report to the Fitness to Practise Committee (FPC).

14. If the Government decides, over and above these initiatives (and the powers of the Council for Healthcare Regulatory Excellence to refer cases to the High Court in certain circumstances), that an independent review and audit is necessary, we should offer our full support. However, it may be more useful if any such work were undertaken prospectively rather than retrospectively, bearing in mind that the replacement of the old fitness to practise procedures with entirely new procedures from 1 November 2004 will mean that conclusions founded on an analysis of historical information could not be regarded as a reliable guide to future practice.

**Recommendation 12: Controlled drugs prescriptions should record a brief description of the patient’s condition, subject to consent (see Annex A for full text)**

15. The Patient and Public Reference Group discussed this recommendation at its meeting on 8 September 2004. Some members expressed concerns that such a process could result in a breach of confidentiality for patients, and that there could be a breakdown of the trust patients should have in their doctors because in seeking consent to disclose the condition, a doctor would have to explain that it was necessary in case he/she made a mistake. However, members noted that the proposal could result in a greater safeguard for patients as the pharmacist could check the prescription against the condition for which it was prescribed.
16. The Group considered that while a pharmacist would have a professional duty to preserve a patient’s confidentiality, this would not extend to a shop assistant receiving the prescription from the patient. Members commented that this could cause particular problems of breach of confidentiality in small communities where individuals tend to be personally acquainted with a high proportion of the population. However, they said that this should be dealt with by thorough staff training and management, to ensure that the onus of preserving confidentiality rests with all staff, whether in a pharmacy or a pharmacy department of a larger store.

17. The Group discussed the possibility of a system of coding, to make it more difficult for a lay person to be aware of the condition for which the prescription was issued. Members agreed that such a system would allay their concerns over possible breach of confidentiality.

18. The Standards and Ethics Committee also discussed this recommendation at its meeting on 21 September 2004. The Committee concluded that no problems relating to consent or confidentiality would arise in implementing this recommendation, provided patients’ consent had been obtained to include the information, and that pharmacists took all reasonable steps to ensure information about the patient’s condition was shared only with those contributing to the provision of the patient’s care.

19. The Committee was concerned, however, that the inclusion of this information on prescription forms would not either help to deter or detect fraud; nor would it add significantly to pharmacists’ ability to identify prescribing errors.

20. The Committee noted that the Report related to controlled drugs in the community, but emphasised that this recommendation would be extremely difficult to implement in a hospital setting.

21. It remains to be seen how the Government will respond, but the conclusions of the discussions by the Standards and Ethics Committee and the Patient and Public Reference Group have been reported to the relevant Working Group.

**Recommendation 14: Single prescriptions for controlled drugs should be limited to 28 days supply**

and

**Recommendation 15: The validity of a prescription for controlled drugs should be limited to 28 days (see Annex A for full text of these recommendations)**

22. Our current guidance indicates that doctors should be familiar with any relevant current national guidance. If the Government accepts these recommendations, we may wish to consider reflecting this in our guidance on prescribing.
**Recommendation 28: Need for more information for patients when prescribed controlled drugs (see Annex A for full text)**

23. The Patient and Public Reference Group have considered and are supportive of this recommendation, implementation of which would result in a pharmacist providing oral and written information and advice to patients. However, it was again concerned about the possibility of a breach of confidentiality and members said that it would be important for there to be a private area for the pharmacist to talk with patients or their representatives.

24. The Standards and Ethics Committee have also considered and are supportive of this recommendation, but suggested that pharmacists should be given advice on ways in which patients' confidentiality and privacy can be respected, for example by providing rooms or areas, away from the main pharmacy, for discussion with patients.