GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL,
(Applying the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988)

On:
Friday 1 July 2005

Held at:
St James's Buildings
79 Oxford Street
Manchester M1 6RQ

Case of:

PATRICK VERNON FINN COSGROVE MB BS 1968 Lond
Registration No: 1278712
(Resumed Hearing)

Panel Members:

Professor J Crane (Chairman)
Mr I Ashraf
Mr M Cann
Mrs P Clarke
Mr J Morecroft
Mrs J Walker (Legal Assessor)

Dr Cosgrove was neither present nor represented.

MR C TEHRANI, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council.

(Transcript of the shorthand notes of Transcribe UK
Tel No: 0208 614 5799)

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THE CHAIRMAN: Good morning, everybody. As you may be aware, the GMC has reformed its Fitness to Practise procedures. The changes took effect on 1 November 2004. The transitional arrangements for cases such as this are that the Committee will now be called a Fitness to Practise Panel but will operate under the existing Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988.

The Panel this morning is going to consider the resumed case of Dr Cosgrove. Dr Cosgrove is not present and is not represented. Mr Christopher Tehrani, counsel, instructed by Field Fisher Waterhouse, solicitors, represents the Council.

First of all, Mr Tehrani, could you let the Panel know the full name and registration details of the doctor, please.

MR TEHRANI: Sir, I have a document of which I believe you have the original copy before you. My copy is not clear, but the full registered name of the doctor, as I read it, is Patrick Vernon Finn Cosgrove. On my copy it is at the very top of the document. His registration number appears in the box "UID", but on mine it is blanked out, so perhaps you could assist me.

THE CHAIRMAN: My copy from the register is 1278712. As Dr Cosgrove is not present or represented, I will ask Mr Tehrani to satisfy the Panel that all reasonable efforts have been made to serve the notice of this resumed hearing.

MR TEHRANI: Sir, I can do that. Perhaps I can hand out some documents to the Panel which will assist.

THE CHAIRMAN: We will call these C1. *(Same handed.)*

MR TEHRANI: Sir, on page 1, you will find a print-out from the GMC's own database regarding registration of doctors. The matters that I refer the Panel specifically to on page 1 are, on the top left-hand corner, you will see the first and surname of the doctor, Patrick Cosgrove. To the right, you will see his address, 129 Church Road, Combe Down, Bath, Avon, and the postcode is given. A bit further down the page, you will see his correspondence name and salutation, which is Dr P V F Cosgrove, and salutation is Dr Cosgrove.

If I can ask you to turn to page 2, please, you will see on page 2 the delivery notification form from the courier firm UPS, and you will note from that, that the documents in question were shipped out on 31 May of this year. They were delivered on 1 June at 1047 am, and they appear to have been signed for by Dr Cosgrove himself. The location was a residential address. If I can ask you to turn to page 3 of the bundle of documents, you will see a further document provided by UPS. You will see that is faxed correspondence and, in that, they confirm that the shipment of the letter or documents in question was made to Dr Cosgrove of 129 Church Road, Bath, which is the same address as appears on page 1 of this bundle of documents. You will see at the bottom there appears to be a signature which purports to be that of Dr Cosgrove.

If I can ask you to turn to page 4, this is the letter from Fiona McQueen, the Assistant Registrar, to Dr Cosgrove, dated 31 May 2005, in which he is given notification of

today's resumed hearing and, again, if I can draw to your attention it is addressed to Dr Patrick Vernon Finn Cosgrove of 129 Church Road, Combe Down, Bath. You will also find, from pages 6 through to page 19, the minutes of the hearing before the Professional Conduct Committee in June of last year.

In all the circumstances, the Council submits that correspondence has gone to the address of Dr Cosgrove, he would appear to have signed for the documents himself, he is fully aware of today's hearing and, as I will outline in due course, he has deliberately chosen not to participate at this resumed hearing.

I can also add one further point of information. My instructing solicitors have been in touch with Dr Cosgrove's solicitors, who have informed them that Dr Cosgrove has not given them any instructions, hence why they are not here today.

THE CHAIRMAN: Thank you, Mr Tehrani. I will just ask our Legal Assessor if she wants to advise the Panel in relation to whether the Panel will wish to proceed or not.

THE LEGAL ASSESSOR: Yes. In relation to the decision whether to proceed in the doctor's absence, there are two issues which I would advise that you should consider. Firstly, you need to be satisfied that all reasonable efforts have been taken to serve the doctor with the notice of the hearing, in compliance with Rule 54, which requires that notices should be sent by personal delivery, or registered post, or another postal service where receipt is recorded to the doctor's usual or last known address.

That means that you have to be satisfied the notice was sent to the doctor's registered or last known address. You do not have to be satisfied that the doctor actually received it, although, of course, you have some information before you today which appears to indicate that certainly the document was signed for and that it may have been signed for by Dr Cosgrove himself.

If you are satisfied that reasonable efforts have been made to serve the notice, then the second question to consider is whether to exercise your discretion to proceed. There is a discretion for this Panel, where a doctor does not appear and is not represented, to proceed with the hearing in their absence, but it is a discretion that you must actively consider and decide whether to exercise.

The courts have made it clear that although a doctor has the right to appear before a Panel, he is not obliged to do so. If a doctor has voluntarily chosen not to attend the hearing, then the hearing may proceed, but if the doctor has previously indicated that he does wish to attend, then it might be unwise to proceed unless there are other overriding circumstances.

In this case, Dr Cosgrove, you may feel, has not given any unequivocal indication as to whether he wishes to attend or not. As I understand it, there is no response from him – a nil response. Therefore, in exercising your discretion as to whether to proceed in his absence or not, my advice is that you should consider the following issues: first, the need to protect patients and to have regard to the public interest and the interests of the doctor; secondly, the seriousness of the case; thirdly, the risk of reaching the wrong conclusion about the doctor's absence; fourthly, the risk of reaching the wrong decision on the merits

of this case as a result of not hearing from the doctor; further, whether an adjournment might result in the doctor attending, and also the extent to which the doctor might be disadvantaged by not being able to give his account of events, having regard to the nature of these proceedings and the evidence against him. So those are the matters that I would advise you to consider in deciding whether to go ahead with the hearing today.

If you decide that it is appropriate to proceed with the hearing in the doctor's absence, then, of course, you must ensure that the hearing is as fair as possible, and that will include drawing no adverse inference from Dr Cosgrove's absence, and ensuring that you do consider any information available to you that is favourable to him. However, at this stage, the decision is whether to proceed without the doctor.

THE CHAIRMAN: Thank you, Legal Assessor. I do not know whether the Panel wants to go into camera to consider this? Is the Panel happy to proceed? *(Agreed*) Mr Tehrani, I think that the Panel has indicated that it is quite content to proceed with these proceedings. We are satisfied that all reasonable efforts have been made to serve the notice of the resumed hearing on the doctor. So, with that in mind, I will ask the Committee Secretary then to read the charge.

THE PANEL SECRETARY: The Panel will resume consideration of the case of Dr Patrick Vernon Finn Cosgrove registered as of 129 Church Road, Combe Down, Bath, Avon, BA2 5JJ, MB BS 1968 Lond; MRCS Eng LRCP Lond 1968, whose registration is suspended until 20 July 2005 in consequence of a direction by the Professional Conduct Committee in January and June 2004 (Minutes June 2004).

The charge that was found proved by the Committee in January 2004 and June 2004 was as follows:

"That, being registered under the Medical Act,

1.At all material times, you were practising as a Consultant Child and Adolescent Psychiatrist working in private practice at the Bristol Priority Clinic;

2. a. On 3 May 1996, you saw Patient A, a child who had been diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD),

b. You prescribed drugs to Patient A as follows:

i. between May 1996 and May 1999, you prescribed methylphenidate (Ritalin),

ii. ……

iii. ……

iv. by May 1999, you had increased the dose of Ritalin to 130 mg per day,

v. from July 1996, you prescribed an additional daily dosage of Risperidone at 1 mg per day,

vi.by November 1998, you had in addition prescribed clonidine as a night-time sedative,

c.Having so prescribed, your monitoring of Patient A was irresponsible in that

i. you did not see Patient A in person between May 1996 and May 1999,

ii. you did not make an adequate assessment of Patient A's weight,

iii. ……

iv. you did not warn Patient A's mother that sudden withdrawal of clonidine could have a deleterious effect on Patient A's blood pressure,

v. you did not advise Patient A's general practitioner (GP) to monitor Patient A as above;

3. a. On 1 December 1999, you saw Mr B as a private patient and diagnosed that he was suffering from ADHD,

b. On 3 December 1999, you wrote a letter about that consultation to Dr Humphreys, Mr B's GP, which letter you copied to Dr K Al-Shabner and to Mr and Mrs B,

c. In that letter, you stated as follows:

i. that Mr B had seen a doctor who might have been Dr Al-Shabner,

ii. that the doctor whom Mr B had seen had been rude and unhelpful,

iii. that the doctor whom Mr B had seen had been scruffily dressed,

iv. that the doctor whom Mr B had seen knew nothing about ADHD,

v. that the doctor whom Mr B had seen was guilty of medical negligence,

vi. that the doctor whom Mr B had seen had demonstrated professional incompetence,

d. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt Dr Al-Shabner's knowledge and/or skills;

4. a. On 27 May 1999, you saw Master C, a nine year old boy, as a private patient,

b. On 29 May 1999, you wrote a letter to Master C's GP about the consultation, sending a copy of the letter to Dr Karin Moses, consultant child psychiatrist responsible for the treatment of Master C under the NHS,

c. The said letter requested that Master C's GP prescribe him Risperidone and Ritalin,

d. The letter did not contain any advice for Master C's GP about appropriate monitoring of Master C whilst he was taking those drugs,

e. Your failure to provide such advice to Master C's GP was

i. irresponsible,

ii. not in the best interests of Master C;

5. a. On 7 July 1999, you wrote a letter to Dr Karin Moses, which letter you copied to Master C's parents and his GP,

b. In that letter, you stated

i. that Dr Moses was likely to deny some or all of what Master C's parents had told you about her treatment of Master C,

ii. that Dr Moses had seen Master C only once whilst he was a day patient on the children's psychiatric unit at St Cadoc's Hospital, Caerleon, Newport, during which period Master C was getting worse and worse when he should have been getting better and better,

iii. that Dr Moses owed Master C's parents an explanation as to why she had not prescribed Ritalin during the time that Master C was a patient at the children's psychiatric unit,

iv. that when Dr Moses first saw Master C he was aged 5 years old, and that she made no diagnosis and that she had done nothing that resulted in alleviating Master C's malfunctioning,

v. that nothing that Dr Moses had done when she saw Master C aged 5, 6 and 7 years had prevented his behaviour causing him to be asked to leave two schools and to be admitted to St Cadoc's Hospital,

c. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt Dr Moses' knowledge and skills;

6. a. In or about May 1996 you saw Master D, a ten year old boy, as a private patient,

b. You diagnosed Master D as suffering from ADHD,

c. You prescribed Ritalin for Master D,

d. Your examination of Master D on that occasion was inadequate in that

i. you did not weigh him,

ii. you did not take his blood pressure,

e. You subsequently spoke to Master D's mother by telephone, following which you prescribed risperidone,

f. You failed to make proper arrangements for monitoring the effects of the treatment which you provided for Master D;

7. a. In or around August 2000, Oxfordshire Mental Healthcare NHS Trust carried out an investigation into a number of features of the treatment of a patient of the Trust, Patient E,

b. On 29 September 2000, Miss Wendy Samways, Complaints Manager at the Oxfordshire Mental Healthcare NHS Trust, wrote to you requesting copies of your medical records concerning Patient E and enclosing signed authorisation for the release of the records,

c. By a letter dated 3 October 2000, you replied to

Miss Samways that you would not supply the medical records,

d. ……..

i. ……..

ii. ……

8. a. In the letter referred to in paragraph 7c above, you also stated as follows:

i. that Patient E had been given inadequate care by an employee of the Oxfordshire Mental Healthcare NHS Trust,

ii. that the investigation being carried out might end in a whitewash of such inadequate care,

iii. that you believed the investigation to be a cover up of grossly inadequate care received by Patient E from the Trust,

iv. that the investigation was programmed to ensure that the Trust was not criticised at all or only criticised in a minor way,

b. The comments set out in the letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of the employees of the Oxfordshire Mental Healthcare NHS Trust who treated Patient E;

9. a. By a letter dated 17 November 2000, concerning a patient Mr F, which you sent to his GP, and copies of which you sent to Dr Helen Chubb, consultant psychiatrist at the Cardiff and Vale NHS Trust and Dr Miranda Thomas, SHO in psychiatry at the same Trust, you stated that you had diagnosed Mr F as suffering ADHD and that you had prescribed him Ritalin,

b. That letter did not contain any advice to the prescribing GP about the monitoring of Mr F,

c. In the letter, you stated as follows:

i. that Mr F had not felt that Dr Thomas had listened to him when he talked about his personal understanding of ADHD,

ii. that Dr Thomas had stated that a "concentration problem is for messy kids",

iii. that the comment alleged to be made by Dr Thomas was an ignorant comment,

iv. that both Dr Thomas and Dr Chubb were arguably guilty of medical negligence in knowing less about ADHD in adults than Mr F,

v. that Dr Thomas had made an assertion of 'therapeutic nihilism' in saying 'the consultant thinks that you have got a personality disorder which is not treatable',

vi. that if Mr F responded to treatment for adult-type ADHD, It would indicate that Dr Thomas and Dr Chubb were negligent in not listening to Mr F and in not knowing about ADHD as a real condition in adults, leaving room for formal complaint to the Fitness to Practice Directorate of the General Medical Council,

d. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of Dr Chubb and Dr Thomas;

10. a. On or around 24 February 2003, you saw a 4 year old child, Patient G, as a private patient,

b. Thereafter, you prescribed Ritalin and risperidone to Patient G,

c. By May 2003, you were prescribing

i. Ritalin at 25 mg per day,

ii. Risperidone at 0.625 mg per day,

d. Having so prescribed, your monitoring of Patient G was irresponsible in that

i. you did not make an adequate assessment of Patient G's weight,

ii. you did not monitor Patient G's growth,

iii ……

11. a. On or around 16 July 2003, you saw Patient H as a private patient,

b. On 19 July 2003, you wrote to Patient H's GP, which letter you copied to Patient H's parents and to Dr Dover, a consultant psychiatrist who had treated Patient H,

c. In that letter you stated amongst other things

i. that, if Dr Dover did not believe in ADHD, he might have difficulty in being revalidated by the General Medical Council,

ii. that Dr Dover should have studied Patient H's school reports,

iii. that Dr Dover had behaved in a professionally unacceptable manner by not arranging a second opinion when asked to do so,

d. The comments that you made in the said letter were

i. unprofessional,

ii. unsustainable,

iii. likely to cause the reader to doubt the knowledge or skills of Dr Dover;'

And that in relation to the facts found proved you have been guilty of serious professional misconduct."

THE CHAIRMAN: Mr Tehrani?

MR TEHRANI: Sir, on 18 June last year, Dr Patrick Cosgrove was found guilty of serious professional misconduct by the Professional Conduct Committee, as you have just heard. Having heard all the evidence in the case and matters advanced in mitigation, the Professional Conduct Committee directed that Dr Cosgrove's registration should be suspended for a period of 12 months, and that the Committee would resume consideration of his case before the end of the period of 12 months. In making that direction, the Committee, on that occasion, said that at this hearing it would expect to receive evidence that Dr Cosgrove had addressed the problems identified throughout the determination, including, first, evidence as to how he would improve his practice towards monitoring patients whom he may treat or for whom he may be responsible; second, evidence that he has improved his communication skills and, third, evidence that he had addressed his attitudinal difficulties. Dr Cosgrove was also told that the Committee would, on this occasion, consider whether to take further action in relation to Dr Cosgrove's registration.

Dr Cosgrove qualified as a doctor in 1968, obtaining his Bachelor of Medicine and Bachelor of Surgery from the University of London. He is a specialist in child and adolescent psychiatry. At the time relevant to the matters with which the Professional

Conduct Committee was, and is still, concerned, he practised from the Bristol Priority Clinic, a private clinic, as a consultant child and adolescent psychiatrist. The heads of charge in the notice of enquiry found proven all arose out of cases in which Dr Cosgrove had been involved with treating patients for Attention Deficit Hyperactivity Disorder. This is a common and well-recognised psychiatric disorder in children and adolescents. Treatment of this condition has been by a variety of techniques, including behavioural management and through the use of medication. Of the medication that has been used in this country, Ritalin is the most commonly used medication. Ritalin, essentially, is a stimulant which has been proved effective in the treatment of Attention Deficit Hyperactivity Disorder.

Dr Cosgrove has worked extensively in this area. He has written on, amongst other things, the use of Risperidone, an anti psychotic drug, to augment the use of stimulants such as Ritalin. It would appear that there are a range of views held by professionals about the use of drugs in dealing with both children and adults who present with Attention Deficit Hyperactivity Disorder. Dr Cosgrove's views lie towards one end of the spectrum, in the sense that he is a psychiatrist who has been more ready than many to prescribe drugs. Many of the heads of charges found proven related to the manner in which Dr Cosgrove had spoken of, and to, other psychiatrists who do not share his views, and lie at different points in the range of options relating to treatment of Attention Deficit Hyperactivity Disorder.

The Professional Conduct Committee last year heard evidence from a Professor Taylor, a child and adolescent psychiatrist, who said in evidence that when treating children and adolescents with such disorders, and making a decision regarding whether or not to prescribe drugs, it was necessary – in fact essential – to undertake a physical examination. A physical examination would include taking height measurements, weight and blood pressure of the patients who are to be prescribed Ritalin and Risperidone, in order to determine whether continued prescribing would be appropriate. The Committee also heard evidence about the European Child and Adolescents Psychiatry guidelines for Hyperkinetic Disorders, published in 1998, on the monitoring of patients to whom Ritalin is prescribed, and to Professor Taylor's own protocol for the monitoring of patients to whom Ritalin in doses of up to 60 mg per day is prescribed.

The Committee found that Dr Cosgrove's monitoring of patients, which normally took place over the telephone rather than face to face, was not sufficient to obtain relevant information for the monitoring of patients and prescribing Ritalin, and fell short of the standards of monitoring which both the European Guidelines and Professor Taylor's own protocol recommended.

In summary, the heads of charge found proven against Dr Cosgrove related to the circumstances surrounding the issuing of prescriptions to a number of individual patients, and a lack of aftercare monitoring and to correspondence arising out of treatment of patients referred to him by others.

I now propose, sir, to go briefly through the factual background in relation to each of the heads of charge. It may help the members of the Panel if they have the actual notice of enquiry before them, and can I refer you, at this stage, to head of charge 2, please. Head of charge 2 relates to Dr Cosgrove's failure to monitor a patient adequately following a

prescription of various drugs between May 1996 and May 1999. Patient A was a child. His GP felt that the patient was showing symptoms of Attention Deficit Hyperactivity Disorder. He was referred by his GP to a Dr Charles Holme, a consultant community paediatrician based at the Salisbury District Hospital. The patient was prescribed Ritalin but was subsequently referred by the patient's GP to Dr Cosgrove. Dr Cosgrove saw the patient and his mother on 3 May 1996. He immediately started prescribing Ritalin. By May 1999, Dr Cosgrove had increased the dose of Ritalin to 130 mg a day. He had also prescribed 1 mg per day of Risperidone from July 1996 and, by November 1998, he was prescribing Clonidine as a night-time sedative to be taken on a daily basis.

130 mg of Ritalin per day is a very high dosage. If such a high dosage of Ritalin is to be prescribed, then monitoring of the patient's weight and growth are essential. This level of dosage was such as to cause concern to Dr Holme, who communicated his concern to Dr Cosgrove. Dr Cosgrove then reviewed the patient, and recommended a reduction in dosage. Subsequently, the patient's case was taken over by another psychiatrist.

If I can refer the Panel to head of charge 2.a., you will see 2.a. and 2.b.i., iv, v and vi basically reflect the summary of the facts that I have just outlined to the Panel and, in respect of head of charge 2.c., you will see that in respect of those facts, the Panel found that Dr Cosgrove's monitoring of Patient A was irresponsible, in that he did not see Patient A in person between May 1996 and May 1999; that he did not make an adequate assessment of Patient A's weight; he did not warn Patient A's mother that sudden withdrawal of Clonidine could have a deleterious effect on Patient A's blood pressure, and that he did not advise Patient A's GP to monitor Patient A as above.

If I can move on to head of charge 3, Patient B was an adult patient of one Dr Humphreys, a GP in Aberystwyth. This patient was referred to a Dr Al-Shabner, a psychiatrist employed by the Pembrokeshire and Derwent NHS Trust. Dr Al-Shabner saw the patient in late 1999. The patient was, at about this time, also referred to Dr Cosgrove. Dr Cosgrove saw the patient on 1 December 1999 and diagnosed ADHD. On 3 December, Dr Cosgrove wrote a letter to Dr Humphreys. A copy of this letter was copied to Dr Al-Shabner and the patient's parents.

Can I pause at this moment, please. Copies of all the letters that have been referred to in the notice of charge have been copied, they are available and I would like to hand copies of the correspondence to the Panel, please. *(Same handed)*

THE CHAIRMAN: This will be C2, Mr Tehrani.

MR TEHRANI: The letter that has just been handed to you is the letter of 3 May 1999. I do not propose to read the letter into the record unless the Panel wishes me to do so. I propose simply to summarise what is contained within the body of the letter. In the letter, sir, Dr Cosgrove set out evidence of the patient's inattentiveness, poor motivation and impulsive behaviour. Dr Cosgrove indicates in that letter that he considered the patient had Attention Deficit Hyperactivity Disorder.

The letter then goes on to deal with the patient's recent appointments with Dr Al-Shabner and if I can ask the Panel, please, to look at head of charge 3.c., at i, ii, iii, iv, v and vi, you will find a summary of what is contained in the second half of the letter. Briefly, in

summary, what Dr Cosgrove had to say in the letter was that Dr Al-Shabner had been rude and unhelpful to the patient; that Dr Al-Shabner, when he had seen Patient B, had been scruffily dressed; that Dr Al-Shabner had seemed to know nothing about ADHD; that Dr Al-Shabner seemed to be guilty of medical negligence, and that Dr Al-Shabner had demonstrated professional incompetence.

When considering the allegations that Dr Cosgrove made in the letter, the Committee found in June of last year that the comments made were unprofessional, unsustainable and likely to cause the reader to doubt Dr Al-Shabner's knowledge and/or skills.

If I can turn to heads of charge 4 and 5 in fact, because they need to be read together, dealing with head of charge 4 first, in November 1998, Patient C started to attend a children's unit at St Cadoc's Hospital, Newport. The patient had daily contact with specialist teaching and nursery staff. He was reviewed weekly at multi-disciplinary staff meetings at which a consultant child psychiatrist, Dr Karen Moses, was present. Subsequently, on or about 27 May 1999, this patient was seen by Dr Cosgrove. Dr Cosgrove then wrote to the patient's GP, by letter dated 29 May 1999, and he copied that letter to Dr Moses and, again, can I hand in to the Panel a copy of that letter, please. *(Same handed)*

THE CHAIRMAN: This is C3.

MR TEHRANI: Again, I do not propose to read it into the record. I will summarise the contents of the letter. In that letter, in summary, Dr Cosgrove expressed the opinion that the patient had Attention Deficit Hyperactivity Disorder; that he had started the patient on a low dose of Risperidone to be followed two days later by a dose of Ritalin and that the dosages would then be increased. The prescription of these drugs without proper monitoring is not appropriate. Dr Cosgrove's letter to the GP contains no advice to the GP about monitoring of the patient, and the Committee found that this failure was irresponsible and not in the interests of the patient.

Moving on to head of charge 5, in that same letter that you have before you, dated 29 May, Dr Cosgrove said that the patient and his mother had said that Dr Moses had seen the patient three times in four years:

> "In view of the serious state that [the patient] is now in, I am surprised that more has not been done for this poor child by the local specialist."

As I have said, Dr Cosgrove sent a copy of the letter to Dr Moses. Dr Moses responded directly to Dr Cosgrove by letter. In that letter – I do not propose to put a copy of that before the Panel – she said:

> "I am most unhappy about your intervention with this boy and with your false assumption that 'not more has been done for this poor child by the local specialist'."

Dr Cosgrove responded to this letter in his own letter, dated 7 July 1999, and copied the letter to the patient's GP and the patient's parents and, again, can I hand in a copy of this letter to the Panel. *(Same handed)*

THE CHAIRMAN: This becomes C4.

MR TEHRANI: The relevant parts of this particular letter, dated 7 July 1999, are summarised in heads of charge 5.b.i, ii, iii, iv and v. In brief, what Dr Cosgrove said in the letter was that Dr Moses was likely to deny some or all of what C's parents had told him about her treatment of him; that Dr Moses had seen Patient C only once while he was a day patient on the children's psychiatric unit at St Cadoc's Hospital in Newport, during which period C was getting worse and worse when he should have been getting better and better; that Dr Moses owed Patient C's parents an explanation as to why she had not prescribed Ritalin during the time that Master C was a patient at the children's psychiatric unit; that when Dr Moses first saw Patient C he was aged five years old; that she had made no diagnosis; that she had done nothing that resulted in alleviating Master C's malfunctioning and, finally, that nothing that Dr Moses had done when she saw Patient C aged five, six and seven had prevented his behaviour, causing him to be asked to leave two schools and to be admitted to St Cadoc's Hospital.

On hearing the whole of the evidence, the Professional Conduct Committee made the following findings of fact in respect of this letter: that the letter was unprofessional, the allegations were unsustainable and the contents of the letter were likely to cause the reader to doubt Dr Moses's knowledge and skills.

If I can move on to head of charge 6, Patient D was born on 12 February 1986. As a result of his poor behaviour at school, his mother became very concerned. Through a family support group, she was put in touch with Dr Cosgrove.

In May 1996, she took her son to see Dr Cosgrove. During the consultation, Dr Cosgrove asked various questions about her son's behaviour, and she completed a questionnaire about her son. Dr Cosgrove did not speak directly to the patient, nor carry out a physical examination – in other words, weigh him or take his blood pressure. Dr Cosgrove diagnosed Attention Deficit Hyperactivity Disorder, and told the patient's mother that he could assist the child by prescribing Ritalin on a private prescription, which he did. Dr Cosgrove indicated that he would check on the patient's progress by telephoning in a fortnight. Dr Cosgrove telephoned two weeks later and was told by the patient's mother that she was still having difficulties with her son's behaviour. Dr Cosgrove indicated that he would increase the dose of Ritalin

Two weeks later, the patient's mother spoke again to Dr Cosgrove by telephone. The mother indicated that she was still concerned about her son, in that he was not eating or sleeping and that he was losing weight. Dr Cosgrove said that he would prescribe another drug which would help her son sleep, and would counterbalance the Ritalin. The drug prescribed was Risperidone.

This particular patient remained on Ritalin and Risperidone for a number of years. However, after the initial first visit, Dr Cosgrove did not see the patient again. As can be seen from the document before you, the notice of enquiry, the Committee last June found that it was inappropriate for the treatment of this patient to continue without monitoring by Dr Cosgrove and, as I outlined at the beginning, the profession is critical and finds it unacceptable for monitoring to take place over the telephone.

If I can turn to heads of charge 7 and 8, they need to be read together. In the summer of 2000, Oxfordshire Mental Healthcare NHS Trust started an investigation into its treatment of Patient E following a complaint by the patient's parents. By the time the complaint was made, Dr Cosgrove was treating the patient. The trust wrote to Dr Cosgrove requesting a copy of his notes of his treatment of the patient. In a letter, dated 3 October 2000, Dr Cosgrove responded by saying that he would not supply the medical records. Again, can I hand in a copy of this particular letter to the Panel. *(Same handed)*

THE CHAIRMAN: C5.

MR TEHRANI: The content of this letter is summarised in heads of charge 8.a.i, ii, iii and iv. In summary, what Dr Cosgrove said was that Patient E had been given inadequate care by an employee – it was in fact a doctor of the Oxfordshire Mental Healthcare NHS Trust; that the investigation being carried out by the trust might end in a whitewash of such inadequate care; that he believed the investigation to be a cover-up of grossly inadequate care received by the patient from the trust and that the investigation was programmed to ensure that the trust was not criticised at all, or only criticised in a minor way. The Committee last June found, in respect of this letter, that it was unprofessional, the allegations made in it were unsustainable and that the allegations were likely to cause the reader to doubt the knowledge or skills of the employees of the Oxfordshire Mental Healthcare NHS Trust who treated Patient E.

Moving on to head of charge 9, Patient F was referred to Dr Cosgrove by his GP in the year 2000. At this time, the patient was also under the care of one Dr Helen Chubb, a consultant psychiatrist at the Cardiff and Vale NHS Trust, and Dr Miranda Thomas, who was Dr Chubb's SHO. Dr Thomas saw the patient during the relevant period. In a letter, dated 17 November 2000…again, can I hand to the Panel a copy of this letter, please. *(Same handed)*

THE CHAIRMAN: This will become C6.

MR TEHRANI: In this letter, dated 17 November 2000, Dr Cosgrove wrote to the patient's GP, but also copied the letter to Dr Chubb and Dr Thomas. He stated in the letter that he had diagnosed the patient as suffering with Attention Deficit Hyperactivity Disorder, and that he had prescribed him Ritalin. The letter did not contain any advice to the GP about monitoring the patient whilst on Ritalin, and went on to make various allegations which are summarised in heads of charge 9.c.i, ii, iii, iv, v and vi. In summary, in that letter, Dr Cosgrove alleged that Patient F had not felt that Dr Thomas had listened to him when he talked about his personal understanding of ADHD; that Dr Thomas had stated that "a concentration problem is for messy kids"; that the comment allegedly made by Dr Thomas was an ignorant comment; that both Dr Thomas and Dr Chubb were arguably guilty of medical negligence in knowing less about ADHD in adults than Patient F; that Dr Thomas had made an assertion of "therapeutic nihilism" in saying "the consultant thinks that you have got a personality disorder which is not treatable", and that if Patient F responded to treatment for adult type ADHD it would indicate that Dr Thomas and Dr Chubb were negligent in not listening to Patient F, and in

not knowing about ADHD as a real condition in adults, leaving room for formal complaint to the Fitness to Practice Directorate of the General Medical Council.

The Committee, in June of last year, in respect of this letter, found that it was an unprofessional letter to write, the allegations contained within it were unsustainable, and it was likely to cause the reader to doubt the knowledge or skills of Dr Chubb and Dr Thomas.

Moving on to head of charge 10, Patient G was born on 14 March 1998. He was seen by Dr Cosgrove in February 2003, when Dr Cosgrove prescribed the child Ritalin and Risperidone in the doses listed in heads of charge 10.c.i and ii., namely the Ritalin was at 25 mg per day and the Risperidone was 0.625 mg per day. Dr Cosgrove wrote to the patient's GP on 20 February 2003.

Subsequently, the patient was seen by Dr Judge, a consultant child and adolescent psychiatrist. Dr Judge discovered that Dr Cosgrove had seen the patient only once, and had not made an adequate assessment of the patient's weight and had not monitored the patient's growth. It is fair to say that in his letter to the GP of 25 February 2003, Dr Cosgrove did make reference to a series of telephone appointments with the patient's parents in order to monitor the patient's progress, and to find the optimum dosage and frequency through the day. Again, as I outlined at the beginning, such monitoring is not sufficient when dealing with medication of this nature.

Moving on to the final head of charge, head of charge 11, Patient H was seen by Dr Cosgrove on 16 July 2003. This patient had been previously treated by a Dr Steven Dover, a consultant in child and adolescent psychiatry. On 19 July, Dr Cosgrove wrote to the patient's GP and, again, can I hand out copies of this letter to the Panel, please. *(Same handed)*

THE CHAIRMAN: This letter becomes C7.

MR TEHRANI: I ought to say that the letter was addressed to the patient's GP, but the letter was also copied to the patient's parents, and also to Dr Dover. In that letter, Dr Cosgrove made various allegations. They are summarised at heads of charge 11.c.i, ii and iii. In summary, what Dr Cosgrove said in the letter was that if Dr Dover did not believe in ADHD, he might have difficulty in being revalidated by the GMC; that Dr Dover should have studied Patient H's school reports and that Dr Dover had behaved in a professionally unacceptable manner by not arranging a second opinion when asked to do so.

The Committee that heard this case last June, in respect of the letter, found that it was unprofessional, the allegations contained within it were unsustainable and they were likely to cause the reader to doubt the knowledge or skills of Dr Dover.

In making its findings of serious professional misconduct, the Professional Conduct Committee made the following comments: regarding the correspondence that had passed between Dr Cosgrove and other doctors, it ruled that the nature of this correspondence went far beyond what amounts to robust criticism, and that he acted in a wholly unprofessional manner in sending these letters. The Committee concluded that

Dr Cosgrove was not in possession of all of the facts pertaining to the issues dealt with in the letters when he made his judgments and, as a consequence, he persistently undermined the opinions provided by other practitioners involved in the care of patients. Furthermore, in copying these letters to the patients or their parents and/or the GP, the Committee ruled that Dr Cosgrove had undermined future patient/doctor relationships, and the future proper medical care of these patients.

The Committee also considered that, in sending those letters, Dr Cosgrove breached the principles contained in Good Medical Practice. The Committee referred to the October 1995, July 1998 and May 2001 editions of Good Medical Practice. In the October 1995 edition, at page 8, paragraph 24, and in the July 1998 edition at page 10, paragraph 29, Good Medical Practice states:

> "You must not make any patient doubt a colleague's knowledge or skills by making unnecessary or unsustainable comments about them."

The same thing appears in similar terms in the May 2001 edition of Good Medical Practice. The relevant reference is paragraph 36 at page 13, which states:

> "You must not undermine patients' trust in the care or treatment they receive, or in the judgment of those treating them, by making malicious or unfounded criticisms of colleagues."

The Committee went on to rule that there was no evidence which suggested that any of Dr Cosgrove's patients suffered harm as a result of Dr Cosgrove's actions. The Committee further ruled there was no doubt that Dr Cosgrove considered he had the best interests of his patients at the forefront of his mind, and the Committee also acknowledged the difficulties Dr Cosgrove faced within the profession with regard to the recognition of Attention Deficit Hyperactivity Disorder and its treatment with medication. The Committee, however, felt that this could not justify Dr Cosgrove's failure to discharge his duties as a treating consultant, and could not be used as an excuse for his lack of patient monitoring and attitude towards colleagues.

The Committee was of the opinion that Dr Cosgrove, as a consultant, should have been working to the highest standards, should have demonstrated good standards of care, and patients and colleagues were entitled to be treated properly and considerately. The Committee was of the opinion that Dr Cosgrove did not demonstrate this consideration. Finally, the Committee concluded that Dr Cosgrove had not demonstrated any remorse or insight into his behaviour.

In making an order for Dr Cosgrove's suspension for a period of 12 months, the Committee said that, at today's hearing, this Panel would expect to receive evidence that Dr Cosgrove had addressed the problems identified throughout that determination, including:

> "Evidence as to how he would improve his practice towards monitoring patients whom he may treat or for whom he may be responsible;
>
> Evidence that he has improved his communication skills;

A

Evidence that he has addressed his attitudinal difficulties."

As I said when I opened the case, the Committee also said that it would, at today's hearing, consider whether to take further action in relation to Dr Cosgrove's registration.

B

As far as the General Medical Council is concerned, there are no new matters that ought to be brought to this Panel's attention.

Regarding Dr Cosgrove's conduct since the determination, the General Medical Council cannot comment on that. Nothing has been brought to its attention, and Dr Cosgrove has not been in contact with the General Medical Council. It is the submission of the Council that the onus is on Dr Cosgrove on this issue, and he has failed to discharge the onus.

C

One point that I ought to say is that, on 16 March 2004, before the substantive hearing in June of last year before the Professional Conduct Committee, Dr Cosgrove wrote to the GMC informing it that he was retired as of that date, or on or about that date. The Council does not know whether or not Dr Cosgrove is still retired. All that we can say is the obvious, and that is that he is suspended.

D

If I can move on to the issue of disposal at this stage, pursuant to paragraph 19 of the Indicative Sanctions Guidance, the decision as to the appropriate sanction to impose in this case is, of course, a matter for this Panel exercising its own independent judgments. What I am about to say are the General Medical Council's submissions which are to assist you in making your decision, and are made pursuant to Rule 28(1). If I can just stress the point again, the submissions I am about to make are no different to any other submissions. You are entitled to accept or reject them, as you do with any other submission.

E

If I can refer the Panel to the latest edition of Indicative Sanctions, it is dated April 2005. If I can refer the Panel to paragraph 16 in section 1-3, you will see, under the subheading of "Proportionality", paragraph 16 reads as follows:

F

> "In deciding what sanctions to impose the Panel should apply the principle of proportionality, weighing the interests of the public (see above) with those of the practitioner, which could include returning immediately, or after a period of retraining to unrestricted practice. In addition the Panel will need to consider any mitigation in relation to the seriousness of the behaviour in question. The extent to which mitigation should influence judgement on a finding of impaired fitness to practise and then on sanction, is dependent on the individual circumstances in the case. The Court of Appeal has made it clear that mitigation will normally be more relevant to sanction."

G

If I can ask you to turn over the page, under the subheading "Sanctions" and "The purpose of the sanctions", paragraph 17 reads:

> "The purpose of the sanctions is not to be punitive but to protect patients and the public interest, although they may have a punitive effect."

H

At paragraph 19, it reads as follows:

> "The decision as to the appropriate sanction to impose is, of course, a matter for the panel. But, the panel must…"

and, in the Council's submission, a. is what this Panel needs to concentrate on:

> "a. Be sure that the action it proposes to take is sufficient to protect patients and the public interest."

If I can ask the Panel, then, to turn to paragraph 31, which is in section 1-7, this deals with review hearings – resumed hearings. Paragraph 31 reads as follows:

> "Where the panel decides that a period of conditional registration or suspension would be appropriate, it must decide whether or not to direct a review hearing immediately before the end of the period. The panel must give reasons for its decision so that it is clear that the matter has been considered and the basis on which the decision has been reached. Where a review hearing is to be held the panel must make clear what it expects the doctor to do during the period of conditions/suspension and the information s/he should submit in advance of the review hearing. This information will be helpful both to the doctor and to the panel considering the matter at the review hearing."

If I can pause there, the Committee did that on the previous occasion, and Dr Cosgrove has singularly failed to comply with the requirements required of him.

At paragraph 32, the Indicative Sanctions reads as follows:

> "It is important that no doctor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the panel can be certain that he or she is safe to do so."

If I can pause there, in the submission of the Council, this Panel cannot be sure that it would be safe to allow Dr Cosgrove to return to unrestricted practice, because he has singularly failed to comply with the requirements asked of him by the Committee back in June of last year.

> "In some misconduct cases it may be self-evident that following a short period of suspension, there will be no value in a review hearing. In most cases, however, where a period of suspension is imposed and in all cases where conditions have been imposed the panel will need to be reassured that the doctor is fit to resume practice either unrestricted or with conditions or further conditions. The panel will also need to satisfy itself that the doctor has fully appreciated the gravity of the offence, has not re-offended, and has maintained his or her skills and knowledge and that patients will not be placed at risk by resumption of practice or by the imposition of conditional registration."

Again, the comments I made a few moments ago are equally apt to the second part of that paragraph.

Can I turn to paragraph 33 of the Indicative Sanctions but, before I do so, may I just submit what the Council's case is in relation to disposal. It is the Council's submission (and again it is only a submission) that the proper way for this Panel to dispose of this case today is by way of erasure. Dr Cosgrove has failed to co-operate with the reasonable requirements of his regulatory body. His suspension last June, for a period of 12 months, gave him an opportunity for rehabilitation, which he has squandered. He is, in the submission of the Council, not deserving of a further opportunity.

If I can draw the Panel's attention to paragraph 33 of the Indicative Sanctions, it deals with erasure and, sir, you will see that it reads as follows:

> "The panel may erase a doctor from the Register in any case, except one which relates solely to the doctor's health, where this is the only means of protecting patients and the wider public interest. The Privy Council has, however, stated that [a panel] should not feel it necessary to erase:
>
> 'an otherwise competent and useful doctor who presents **no danger** to the public in order to satisfy [public] demand for blame and punishment'."

Sir, if I can ask the Panel to turn to section 1-15, dealing with what appears at section 1-15, you will see there is a list of matters this Panel ought to consider when deciding whether erasure is the appropriate penalty. You will see it reads as follows:

> "This sanction…"

Erasure,

> "… is likely to be appropriate when the behaviour is fundamentally incompatible with being a doctor and involves **any** of the following…"

It is the final matter that I draw to the Panel's attention, and that is:

> "Persistent lack of insight into seriousness of actions or consequences".

The Committee concluded that Dr Cosgrove had not demonstrated any remorse or insight into his behaviour as at June of last year and, in the submission of the Council, the position still has not changed, because Dr Cosgrove has failed to co-operate or assist this Panel at this resumed hearing by providing any information as to how he proposes to remedy his shortcomings.

If I can refer the Panel now to section 2 of the Indicative Sanctions, S2-4, you will see, about a quarter of the way down the page, the subheading:

> "Expressions of regret and apology"

by the doctor. In particular, I refer the Panel's attention to paragraph 19, which reads as follows:

> "This 'insight' - the expectation that a doctor will be able to stand back and accept that with hindsight, they should have behaved differently, and that it is expected that he or she will take steps to prevent a reoccurrence - is an important factor in a hearing. But the panel should be aware that there may be cultural differences in the way that insight is expressed, for example, how an apology or expression of regret is framed and delivered and the process of communication."

In the submission of the Council, Dr Cosgrove has no insight regarding the shortcomings in his behaviour, as demonstrated before the Committee in June of last year.

There is one final matter which I would like to draw the Panel's attention to, which I should have done earlier on. If I can ask the Panel to go back to section 1-8, please, paragraph 35 reads as follows:

> "The *Gupta* judgment emphasised the GMC's role in maintaining justified confidence in the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk:
>
> 'The appellant's behaviour had demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession'."

It is the Council's submission that Dr Cosgrove has shown a blatant disregard for his regulatory body by failing to attend today, and by not providing this Panel with any information that would assist it in discharging its duties in deciding how to progress with Dr Cosgrove's case.

Unless I can assist any further with any matters, those are the submissions of the Council.

THE CHAIRMAN: Thank you, Mr Tehrani. Does any of the Panel have any questions for Mr Tehrani? *(Pause.)* It is just after eleven, Mr Tehrani. I think it might be an appropriate time to have a short break. We will come back at twenty past eleven, and then we will seek the advice of the Legal Assessor to advise the Panel. So we will adjourn until twenty past eleven.

(The Panel adjourned for a short time.)

THE CHAIRMAN: I think you had finished your submission to the Panel, Mr Tehrani, is that correct?

MR TEHRANI: Yes, I had.

THE CHAIRMAN: I will now ask our Legal Assessor if she has any advice she would like to give the Panel.

THE LEGAL ASSESSOR: I do have some advice to give to the Panel. You are now at the stage of considering Rule 43, which is the procedure at a review hearing where the registration of the doctor has been previously suspended. Accordingly, you should

proceed in accordance with that rule, which requires the Panel to, firstly, consider whether it will be sufficient to make no further direction; if it is not, to consider directing that the doctor's registration be subject to conditions for a period which could be up to a maximum of three years. If you consider that is not sufficient, then you should consider directing that the current period of suspension be extended for a further period up to 12 months, and if you decide that it is not sufficient to adopt any of those courses of action, then you should direct that the doctor's name be erased from the Register.

In deciding which course of action is appropriate and sufficient, you will need to consider whether Dr Cosgrove is now fit to resume unrestricted practice, and whether patients would be at risk by his doing so.

Mr Tehrani has drawn your attention to a number of issues and to parts of the Indicative Sanctions Guidance. I hope you will forgive me if, in the course of my advice, I repeat some of the points that Mr Tehrani has made, but I think it is important to do so to provide a comprehensive picture. At the hearing last June, as you know, the Professional Conduct Committee indicated that it would expect to receive evidence that Dr Cosgrove has addressed the problems identified by it, including evidence as to how he would improve his practice towards monitoring patients whom he may treat or for whom he may be responsible; evidence that he has improved his communication skills, and evidence that he has addressed his attitudinal difficulties. The Committee also indicated that Dr Cosgrove would be asked to supply names and addresses of professional colleagues to whom the Council may apply for information as to his conduct since the hearing.

His compliance with those requirements is a matter that you will wish to consider in deciding whether further restrictions are required in respect of Dr Cosgrove's practice, or not. You should, of course, have regard to the Indicative Sanctions Guidance, which provides guidance on the decision-making process, and the factors to be considered when dealing with the question of sanctions. You are, as Mr Tehrani pointed out, expected to make your own decision, and exercise your own judgment, in each individual case but you should do so within the framework reflected in the guidance. I do not propose to go through the guidance in great detail. You do, of course, have copies available, and have been referred to those copies already, but I would draw your attention to the following matters.

As Mr Tehrani outlined, the purpose of sanctions is not to be punitive, but it is to protect patients and the public interest. Although sanctions may, of course, have a punitive effect, the public interest includes the protection of patients, the maintenance of confidence in the profession, and declaring and upholding proper standards of conduct. It may also include a doctor's return to safe work.

In deciding what action is appropriate, the Panel should apply the principle of proportionality, balancing the public interest and the protection of patients with those of the doctor. Paragraphs 31 and 32 of the guidance relate to review hearings, and the guidance there emphasises that it is important that no doctor should be allowed to resume unrestricted practice, following a period of conditions or suspension, unless the Panel can be certain that he is safe to do so. The guidance states that in most cases where suspension has been imposed, the Panel will need to be reassured that the doctor is fit to resume practice, either unrestricted or with conditions, and will need to satisfy itself that

the doctor has fully appreciated the gravity of the offence, has not re-offended, has maintained his skills and knowledge, and that patients will not be placed at risk by the doctor resuming practice with or without conditions.

If you decide it is necessary to impose further restrictions on Dr Cosgrove's registration, in the form of either conditions or a further suspension, then you should, of course, consider again ordering a review hearing immediately before the end of the period, and again make clear what Dr Cosgrove is expected to do during that period, and make clear the information he should submit in advance of any further review hearing.

In deciding what course of action is appropriate, the Indicative Sanctions Guidance provides guidance on the kind of circumstances which may render a particular sanction appropriate. I would just refer you to the guidance in relation to the three sanctions available to this Panel. Firstly, in relation to conditions, paragraphs 22 to 26 of the guidance deal with that issue, and state that conditions might be appropriate where there is evidence of incompetence or significant shortcomings in the doctor's practice, but where the Panel can be satisfied there is potential for the doctor to respond positively to retraining and supervision of his or her work.

Paragraphs 27 to 30 deal with suspension, and state that this can be used to send a signal about what is regarded as unacceptable behaviour, and also states that it is likely to be appropriate in cases of deficient performance in which the doctor poses a risk of harm to patients, but where there is evidence that he has gained insight into his deficiencies and has the potential to be rehabilitated. The guidance confirms that, in such cases, the Panel may direct a review hearing, and recommend the action which the doctor should take during the period.

Erasure is dealt with at paragraph 46. At paragraph 46, under the general hearing of "Erasure", there is some guidance on cases where the doctor has failed to provide an acceptable level of treatment or care, which falls well below the expected professional standards. The guidance states there that a particularly important consideration in such cases is whether or not the doctor has, or has the potential to develop, insight into those failures, and it states that where this is not evident, it is likely that conditions or suspension may not be appropriate or sufficient.

The guidance also contains checklists of relevant factors in respect of each of the sanctions, which you may find helpful, and those are found at section 1, pages 13 to 15. Mr Tehrani did refer you to the checklist in relation to erasure and, in particular, drew your attention to the final matter stated in that checklist.

You will appreciate that these are simply extracts from the guidance which I have referred you to, and I would urge you to refer fully to the whole of the guidance, and read fully the whole of the sections in relation to the various options available to you.

Finally, I would remind you, as Mr Tehrani said, that the submissions he made on behalf of the GMC are purely submissions. You should, of course, take them into account, but you should not be unduly influenced by them, and you should exercise your own independent judgment.

Finally, Dr Cosgrove is not here, and I would remind you that you should not draw any adverse inferences from his absence. I think Mr Tehrani suggested that you could view his absence as a blatant disregard of the procedures of this Panel, but my advice to you is that that would not be appropriate – that he is not obliged to attend before this Panel and it would not be appropriate to draw any adverse inferences, or hold that absence against him. Equally, of course, you cannot speculate about what he might have said to you if he was here, and you can, and should, only reach your decision based on the evidence and the information which you have before you.

That does in fact conclude my advice.

THE CHAIRMAN: Thank you, Legal Assessor. There is one matter that maybe Mr Tehrani and the Legal Assessor can help me with. Mr Tehrani, you have perhaps suggested that Dr Cosgrove has, if you like, disregarded the GMC by his failure to turn up, and you referred us to the Indicative Sanctions Guidance. I was looking at the determination, and often in determinations it will indicate that the Panel would expect the doctor to attend, but in fact in the determination it has not actually said that he would be expected to attend. It seems to me that if that had been indicated, then the Panel could draw an inference from that. *(Pause)* I have just been actually drawn to the bit that he was expected to attend. I am sorry, I did not see that. I wonder, then, can the Legal Assessor comment on that. You said not to draw an inference from it, but I see there that in the determination ---

THE LEGAL ASSESSOR: My advice would remain that where a doctor is absent, what he has is a right to attend before a hearing. There is no obligation on him to attend before the hearing, and my advice would remain that, firstly, you have to be very wary of the danger of reaching a wrong conclusion about the reasons for a doctor not attending when no reasons have been put forward and, of course, there are no reasons put forward. We have simply the failure of the doctor to attend or respond. So, that is a very real danger in drawing conclusions about why he has not come, and what his motives or reasons for that may be.

Additionally, my advice would remain that where a doctor has not attended, it would be wrong to draw an adverse inference. Clearly, where a doctor has not attended and has not provided any information to the Panel, there is an absence of positive information, if I can put it that way, which may have otherwise been available. You cannot speculate about what he may have said, so the doctor, by not attending and not responding, is putting the Panel in a position where there is nothing positive that he has put forward and, to that extent, he has to live with that. However, my advice would be that it would be wrong to view his absence adversely – positively adversely.

THE CHAIRMAN: Thank you for that. Mr Tehrani, have you any comments to make?

MR TEHRANI: May I just say that I agree with all that your Legal Assessor has said. I perhaps expressed myself rather inelegantly when dealing with Dr Cosgrove's absence. His absence today should not be held against him. I was framing my submissions in the sense that he has failed to provide this Panel with the information that is required of him, and that could show a persistent lack of insight into his shortcomings as a doctor in terms

of treatment, prescribing and also when dealing with colleagues. That was the sense I was trying to get across, rather than the fact that he has not attended today.

THE CHAIRMAN: Thank you very much for clarifying that. Are there any other matters that the Panel wish to raise?

MRS CLARKE: On page 11, in the fourth paragraph down, there is a sentence that begins:

> "The persistent nature of his inappropriate and unprofessional conduct from 1996 to 2003, which included a period after which he became aware that his conduct was under review by the GMC, provided evidence of the presence of attitudinal difficulties."

I do not think any reference was made to that this morning, and I am not aware of any evidence of the precise timing of when the doctor in question became aware that his conduct was under review by the GMC. Are we able to rely on that sentence?

MR TEHRANI: I am sorry, I cannot assist on that point. I do not have the original paperwork in this case and, in particular, the pink papers relating to the initial investigation, the sending of the Rule 6 letter and the response to the Rule 6 letter, and I really cannot take the matter any further.

THE CHAIRMAN: I presume, though, because it is in the determination, that we can assume that there must have been an investigation.

MRS CLARKE: Yes, so it would have the same effect as if we had seen the evidence first hand here today.

THE CHAIRMAN: Yes, I think we accept the determination, is my understanding.

THE LEGAL ASSESSOR: My advice would be that you can accept that determination as it stands. Obviously, it would be important not to read too much into that, because you have not got any details of the seriousness or the circumstances of that. However, on the face of it, clearly, there was a finding by the previous Committee that the conduct in question persisted after the doctor became aware that GMC activity was being conducted, but I would caution you not to read any more into it than that. You can simply take it at face value, but would have to be careful about the weight that you gave that.

THE CHAIRMAN: Thank you, Legal Assessor.

MR TEHRANI: I am told that if the Panel would like the dates when the investigations first started, and when the PPC first became involved in the case, those dates could be obtained.

THE CHAIRMAN: Mrs Clarke, do you want those dates?

MRS CLARKE: No. Now that I have heard the Legal Assessor's guidance on that, I am satisfied, thank you.

THE CHAIRMAN: Very well. In that case, thank you, Legal Assessor, for your advice. Mr Tehrani, the Panel will now go into camera and consider these matters. I expect it will probably take us up to the luncheon break. Obviously, I cannot give you a time when we will be back, but we will send somebody to let you know.

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

STRANGERS HAVING BEEN READMITTED

D E T E R M I N A T I O N

THE CHAIRMAN: Mr Tehrani, This case has been considered by a Fitness to Practise Panel applying the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988.

Dr Cosgrove was neither present nor represented during this case. The Panel received evidence as to the service of notice of this hearing. The Panel determined that service had been effected pursuant to Rule 54 of the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules Order of Council 1988, as amended. The Panel then considered whether to exercise its discretion and to hear the case in Dr Cosgrove's absence. It concluded that Dr Cosgrove would not suffer any injustice should it do so and determined to proceed to hear the case.

In June 2004 the Professional Conduct Committee found that Dr Cosgrove had prescribed drugs to a number of patients who were diagnosed as suffering from Attention Deficit Hyperactivity Disorder (ADHD). He did not take appropriate steps to monitor these patients whilst they were taking the prescribed drugs and as such acted irresponsibly and not in the best interests of the patients. The Committee also found that on a number of occasions Dr Cosgrove sent letters to other medical practitioners involved in the care of

these patients and had copied these letters to the patients or their parents. In these letters he had made comments, which were unprofessional, unsustainable and likely to cause the reader to doubt the knowledge and skills of the practitioners referred to within the letters.

The Committee concluded that Dr Cosgrove's behaviour was a serious departure from the standards of care and conduct expected of a registered medical practitioner and accordingly found him guilty of serious professional misconduct. The Committee found that Dr Cosgrove did not demonstrate insight into his failings. He had persisted in inappropriate and unprofessional conduct from 1996-2003, which included a period after which he became aware that his conduct was under review by the GMC. He had not expressed any remorse or regret for his actions and had not taken any rehabilitative steps to remedy the matters, which had brought him before the GMC. The Committee suspended his registration for a period of 12 months. The Committee also directed the immediate suspension of his registration. The substantive direction of suspension came into effect on 21 July 2004.

The Committee directed that a resumed hearing of the case would take place before the end of the period of suspension. Dr Cosgrove was informed that at this hearing, the Panel would expect to receive evidence that he had addressed the problems identified at the previous hearing, including:-

- Evidence as to how he would improve his practice towards monitoring patients whom he may treat or for whom he may be responsible;
- Evidence that he has improved his communication skills;

- Evidence that he has addressed his attitudinal difficulties.

The Committee also indicated that before the resumed hearing he would be asked to furnish the GMC with the names and addresses of professional colleagues and persons of standing to whom the Council could apply for information as to his conduct since the previous hearing.

The Fitness to Practise Panel has today resumed consideration of Dr Cosgrove's case. It has considered the evidence placed before it, including copies of the letters produced at the original PCC hearing. The Panel were concerned by the content of those letters which were sent to colleagues and copied to the patients or their parents and which contained unsustainable criticisms against other medical practitioners and cast doubts on their clinical competence. The Panel were also concerned by his failure to adequately monitor patients to whom he had prescribed powerful drugs over a long period of time.

The Panel has not been presented with any evidence to indicate that Dr Cosgrove has taken steps to address the problems identified at the previous hearing and which led to his suspension. He has not complied with the Committee's request to submit the names and addresses of professional colleagues who can give references in relation to his conduct since his suspension. As a consequence no references have been received.

The Panel has considered your submissions as to the appropriate sanction, if any, to take against Dr Cosgrove's registration. It has also considered the advice of the Legal Assessor and has had regard to the guidance contained within the GMC's Indicative Sanctions Guidance – April 2005. In particular it has considered paragraph 31 of the

guidance in relation to review hearings and the information that the Panel would wish the doctor to submit in advance of the review hearing.

The Panel were particularly concerned about Dr Cosgrove's persistent lack of insight into the seriousness of his misconduct and, furthermore, his failure to comply with the requirements of the previous Committee which demonstrated a blatant disregard of his obligations to the GMC.

In considering this case, the Panel has taken into account that Dr Cosgrove has not responded to any correspondence from the GMC since the hearing in June 2004. The Panel has no information with regard to his future plans in continuing to practise medicine albeit he had previously indicated that he was retiring from practise in March 2004. It has not received any information, which demonstrates that he has reflected on the matters, which brought him before the GMC, nor is there any information to show that he has apologised either to his patients who he had failed to monitor adequately or to his professional colleagues of whom he had made malicious and unfounded criticisms.

The Panel has also carefully considered the issue of proportionality, but it is mindful that it is the duty of this Panel to protect patients, to maintain public confidence in the medical profession and to uphold proper standards of behaviour of medical practitioners.

Against this background the Panel considered that in order to protect the public, maintain public confidence in the medical profession and to maintain proper standards required of medical practitioners, it would be insufficient to take no further action, or to impose conditions. The Panel then considered whether a further period of suspension would be

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an appropriate sanction. It is clear that Dr Cosgrove has not complied with the directions of the previous Committee and in so doing has demonstrated a blatant disregard of the GMC's requirements of him. Furthermore, the Panel has received no evidence that he has shown any insight in respect of his previous behaviour and concludes that a further period of suspension would be insufficient. The Panel finds Dr Cosgrove's conduct to be incompatible with that of a registered medical practitioner and has concluded it would be proportionate and appropriate to erase Dr Cosgrove's name from the Medical Register.

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The effect of the foregoing direction is that, unless Dr Cosgrove exercises his right of appeal, his name will be erased from the register 28 days after the date when written notice of the direction is deemed to have been served upon him. A note explaining his right of appeal against this decision will be sent to him. In the meantime, the current period of suspension of his registration will continue until the new direction takes effect. That concludes this hearing.

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