

Fitness to Practise Determination

The following case was heard by a Fitness to Practise Panel. It is presented here to give an example of one possible outcome of breaching a principle in *Good Medical Practice*. It is not intended to give a clear threshold between acceptable and unacceptable behaviour. Each case which comes before a Fitness to Practise Panel is judged on its own merits and assessed on the particular circumstances of the case.

Summary

The doctor treated patients in slimming clinics not registered with the appropriate bodies. Following inadequate assessment of patients, he prescribed drugs not recommended in the management of obesity, and did not attempt to manage their weight with non-pharmacological treatment. He did not inform patients' GPs, did not explain the importance of informing their GP that they were taking the medication, and did not ensure adequate monitoring of effects of medication. Finally he allowed a doctor whose name had been suspended from the Medical Register to examine patients in the clinic, and then signed the patients' record cards himself.

Relevant paragraphs of *Good Medical Practice*

The case relates to the *Good clinical care* section of GMP, specifically paragraphs 2a, 3b, 3c and 3f on providing good clinical care and paragraph 4 on supporting self-care. It also relates to paragraph 13 on keeping up to date and paragraphs 21e and 22b of the section on *Relationships with patients*. The case also relates to paragraph 43 on conduct and performance of colleagues, and paragraphs 52 and 53 on sharing information with colleagues, both in the *Working with colleagues* section.

Determination on impaired fitness to practise

“Dr X: On the [date removed], the Panel announced its findings on the facts. It now has to determine whether, on the basis of the facts admitted and those found proved, your fitness to practise is impaired pursuant to Section 35C (2) (a) of The Medical Act 1983, as amended, by reason of your misconduct. The Panel notes that Mr P, on behalf of the GMC, has submitted on the basis of the facts admitted and the facts found proved that your fitness to practise is impaired by reason of your misconduct.

You have accepted through your Counsel that your fitness to practise is impaired. However, notwithstanding this concession, it is for the Panel to determine this as a matter of judgment.

The Panel has also borne in mind the advice of the Legal Assessor, which sets out the basis upon which this issue is to be determined. In particular she drew the Panel's attention to the recent case of *Harry v GMC* [2006] EWHC 3050 (Admin) in which Goldring J stated that, in reaching its determination on the impairment of a doctor's fitness to practise, the Panel must first determine whether there has been misconduct and, if so, it must go on to ask itself whether that misconduct has impaired the doctor's fitness to practise. Goldring J also stated that, in deciding whether there has been misconduct, it is not possible to ignore the public interest in the wider sense. That interest is an integral aspect when deciding whether the particular facts proved have passed the threshold and amount to misconduct.

The Legal Assessor also advised the Panel of the definition of misconduct given by Lord Clyde in *Roylance v the GMC Privy Council Appeal number 49 of 1998* namely, *"misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances"*.

She also advised the Panel in relation to the recent Court of Appeal Judgement in the case of *GMC v Professor Sir Roy Meadow* (Case No. CO/5763/2005). It noted that the measure of misconduct has not changed under the GMC's new Fitness to Practise Rules, 2004, from that of the old test of serious professional misconduct. Lord Justice Auld stated:

"Given the retention in the Act in its present form of section 1 (1A) setting out the main objective of the GMC to protect, promote and maintain the health and safety of the public, it is inconceivable that "misconduct" - now one of the categories of impairment of fitness to practice ... should signify a lower threshold for disciplinary intervention by the GMC."

The Panel also noted the citations in the case of *Meadow* from the judgement in *Roylance v GMC* ([2000] 1 AC 311) as to the type of conduct which may amount to serious professional misconduct, where Lord Clyde stated that it is conduct which brings the profession into disrepute and it must be serious. The Court of Appeal also approved the words of Mr Justice Collins in the case of *Nandi v GMC* ([2004] EWHC (Admin)) as to seriousness where he referred to it as *"conduct which would be regarded as deplorable by fellow practitioners."* The Panel has further noted the judgement in the case of *Preiss v The General Dental Council* [2001] in which it was stated that serious professional misconduct may take the form, not only of acts of bad faith or other moral turpitude, but also of incompetence or negligence of a high degree.

The Legal Assessor further advised that the Panel has to consider whether a doctor's fitness to practise is impaired today. This decision particularly when the case relates to past conduct can be made on that basis. However, she also advised the Panel that it should have regard to subsequent events also.

The Panel has heard your case with that of Dr Y but has considered each case separately.

The facts of this case are as follows: You have admitted that, at all material times and on the dates specified in the following paragraphs, you were a registered medical practitioner in the UK. During a period known to you commencing prior to [date removed], you provided or assisted in the provision of medical services at a slimming clinic at XXXX ("the S Clinic").

From a date known to you until [date removed], you provided or assisted in the provision of medical services at a slimming clinic at the XXXX at XXXX ("P Clinic"). The slimming clinics referred to above were independent clinics pursuant to section 2 of the Care Standards Act 2000 (as amended) to which the requirements for registration imposed by the Care Standards Act 2000 applied. During the course of your work at these slimming clinics you were aware of, or should have been aware of, the need for registration of those clinics pursuant to the Care Standards Act 2000. No such registration had been granted in relation to the P Clinic and no such registration had been granted in relation to the S Clinic until [date removed].

You have admitted that your provision of medical services at the S Slimming Clinic and the P Clinic during periods when they were not registered was inappropriate, unprofessional, and likely to bring the profession into disrepute.

You have admitted that, for the purposes of the S Clinic, you procured and/or obtained medication including diethylpropion and phentermine during a period when the clinic was not registered. Diethylpropion and phentermine are Class C controlled drugs under Schedule 2 Part III of the Misuse of Drugs Act 1971 and diethylpropion is regulated by the Misuse of Drugs (Safe Custody) Regulations 1973 (as amended). Pursuant to those regulations, drugs should be stored in a secure controlled drugs cabinet or locked receptacle with the means to prevent unauthorised access.

On [date removed], an inspector authorised by the National Care Standards Commission visited the S Clinic. During the course of that visit the receptionist transferred the controlled drugs phentermine and diethylpropion from tubs into brown medicine bottles on the reception desk and the receptionist gave patients tablets for which they paid cash.

In relation to your conduct during the inspector's visit, you delegated the provision of medical services, namely the dispensing of drugs, to an unregistered person. You also caused or allowed persons to be in possession of controlled drugs when they were not authorised to do so. You have admitted that controlled drugs, namely diethylpropion and/or phentermine, were not in your control at all times and that you did not store diethylpropion or other controlled drugs safely, properly, and/or in accordance with the Misuse of Drugs (Safe Custody) Regulations 1973 (as amended).

The Panel has found that, on dates known to you after [date removed] whilst you were working at the S Clinic, you signed patient records without examining the patient. You signed patient record cards when the patient had been examined by XXXX at a time when he was not a person registered under the Medical Act 1983 as amended.

You have admitted that on dates between [date removed] and [date removed] you prescribed medication to patients who attended the P Clinic. You prescribed drugs,

namely diethylpropion and phentermine which are not recommended in the management of obesity and you also prescribed drugs, namely diuretics, which are not recommended in the management of obesity. You prescribed drugs in combinations which are not recommended in the management of obesity. You also prescribed drugs to patients with a BMI of less than 27. You did not record the patient's pulse and you did not always record the patient's blood pressure. During the course of these proceedings you admitted that you did not ensure that adequate monitoring was in place in respect of the effects of such medication.

You have admitted that, on a number of occasions during [date removed], you saw Mr B in consultation at the P Clinic. You did not inform Mr B's General Practitioner that you were treating him. You did not explain to Mr B the importance of notifying his GP of the medication he was receiving from the slimming clinic.

You have admitted that, in exchange for payment to the clinic, you prescribed diethylpropion to Mr B without attempting to help Mr B to manage his weight with non-pharmacological means prior to prescribing medication, without an adequate medical examination being performed, without a sufficiently detailed medical history being taken, without providing sufficient information about the nature and side effects of the medication and without adequate monitoring for effects. You have admitted that diethylpropion is not recommended in the BNF or by the Royal College of Physicians in the management of obesity.

You have admitted that, on [date removed], an annual inspection was carried out at the S Clinic by Inspectors from the Healthcare Commission. The Inspectors considered patient record cards and noted you prescribed 6 weeks supply of diethylpropion to a patient with a BMI of 27 with no co-morbidities on the first visit. You prescribed medication to a patient with a BMI of 26 and provided further medication even though that patient had gained 4 pounds in weight.

You have admitted that your conduct in relation to the admissions made was inappropriate, irresponsible, unprofessional, not in the best interests of patients and likely to bring the profession into disrepute. The Panel also found that your conduct in relation to the allegations which were not admitted by you but were found proved was inappropriate, irresponsible, unprofessional, not in the best interests of patients and likely to bring the profession into disrepute.

The Panel has been greatly concerned by the facts admitted and found proved in this case and has been assisted by the evidence of the numerous witnesses who attended in person before it.

This case concerns your involvement in a number of slimming clinics, which were open for short periods of time and poorly organised. Slimming clinics were and are subject to registration as independent clinics under the Care Standards Act 2000 and you admitted that the clinics you were involved in were not registered excepting that the Sunrise Clinic became registered in March 2005.

Good Medical Practice (2001 edition) at paragraph 11 states:

'Some parts of medical practice are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practice which affect your work.'

You became aware in March 2004, when inspectors from the National Care Standards Commission first visited the Sunrise Clinic, that it was not registered under the Care Standards Act 2000. Despite this knowledge, you continued to work at the clinic.

You have admitted a number of shortcomings in relation to your prescribing medication to patients who attended the Slimming Clinics and in particular Mr B. The Panel has taken account of the evidence of Mr E, the GMC expert witness in the management of obesity, regarding the appropriateness of your prescribing. His view is that the first step in the management of overweight or obese persons should be to look at their lifestyle including diet and physical activity and that drugs should never be used as first line management. In relation to the significance of medical history, Mr E stated that this is extremely important as the patient may have other conditions that preclude the use of medication, for example, existing cardio-vascular disease such as angina or previous myocardial infarction. They may be on medication that might interact with medication that a doctor was planning to prescribe. A doctor needs to look for possible reasons for weight gain and for co-morbidities. Thus there are many reasons why a history is very important.

He also stated that it is important to examine patients to look for other potential causes of obesity, such as a thyroid disorder or even rare diseases like Cushing's Syndrome. It is also important to look for co-morbidities and, when prescribing drugs that may act on the cardio-vascular system, to examine the cardio-vascular system, as it is known that drugs such as phentermine have been associated with a condition called primary pulmonary hypertension, a rare side effect of anti-obesity medication. Again, examination of the cardio-vascular system or respiratory system would be important to ensure that there was no prior pathology in those systems.

The Panel has heard that there are proper standards for drug treatment in the treatment of obesity. The prescription of drugs may be considered in patients who are well motivated but who have not been able to achieve a target weight loss of ten per cent in spite of supervised efforts to modify lifestyle through diet, exercise and behavioural change over a period of three months.

Mr E referred the Panel to his own practice and the guidance from the Royal College of Physicians in relation to the drug treatment of overweight patients. The consensus view is that patients with a BMI of 28 or more with co-morbidities may be considered for drug treatment.

You have admitted prescribing phentermine and diethylpropion to patients - including Mr B.

Phentermine is a centrally-acting drug thought to suppress appetite. It has the potential to induce dependence and is known to have significant side effects on the central nervous system, in particular irritability and anxiety. It has been the subject of a dispute in the European Union over marketing authorisation. The drug was withdrawn in the year 2000 but reinstated in 2002, so it remains a licensed drug

within the United Kingdom. It is a controlled drug of class C. It is a drug which is not recommended for obese or overweight patients either in the British National Formulary or in obesity guidance such as that issued by the Royal College of Physicians.

The Panel has heard that diethylpropion (DEP), which is sometimes known as Tenuate-Dospan is a central appetite suppressant, again a controlled drug of class C. It has been the subject of dispute in Europe with the licence being withdrawn in 2001 but reinstated in 2001 and then again withdrawn and reinstated following a further appeal in 2002. It remains a licensed drug in the United Kingdom albeit not one recommended by the BNF or the Royal College of Physicians' guidelines. DEP, but not phentermine, is subject to the restriction on the storage of drugs, which is contained in the Misuse of Drugs (Safe Custody) Regulations 1973. Those regulations require drugs so far as possible to be stored in a secure controlled drugs cabinet or locked receptacle with a means to prevent unauthorised access or in a locked room.

Mr E made it clear in his evidence that none of the guidance on obesity recommends the use of this drug.

The Panel has been referred to the guidance contained in The Royal College of Physicians report entitled 'Clinical Management Of Overweight And Obese Patients' which gives an indication of the state of knowledge in respect of the clinical management of overweight and obese patients as at December 1998 and it contains at pages 681 to 682 a useful summary.

At paragraph 3 there is reference to:

"A first line strategy for weight loss and its maintenance is a combination of supervised diet, exercise and behaviour modification.

4. The use of anti-obesity drugs may be justified in adult patients at medical risk from obesity (BMI of 30 or greater) or overweight patients with established co-morbidity (a BMI of 28) if the drug licence permits where dietary lifestyle modifications have been unsuccessful in achieving a ten per cent weight reduction after at least three months of supervised care."

There is also reference under paragraph 3 to principles to be followed in prescribing drugs for the treatment of obesity in respect of adequate history taking, examination, adequate understanding from the patient, following current authoritative advice, not prescribing in excess of proper dosages and monitoring.

There is also at paragraphs 4 and 5 reference to the issue of consultation and shared information with general practitioners. Paragraph 4 states:

"You must inform the patient's general practitioner before starting treatment unless the patient objects to disclosure.

5. Where patients do not wish their GP to be informed or have no GP you must take responsibility for providing all necessary aftercare for the patient and if you propose to prescribe anti-obesity drugs you must ensure the patient is not

suffering from any medical condition or receiving any other treatment which made the prescription of drugs unsuitable or dangerous.”

The guidelines further state that if doctors are considering prescribing drugs for the treatment of obesity, following the principles in Good Medical Practice, it is essential that they examine the patient before prescribing and satisfy themselves that the patient has understood what is proposed, and consents to it, before they prescribe. The guidance further emphasises that they must explain to the patient the importance and benefits of keeping their general practitioner informed. They must inform the patient's GP before starting treatment, unless the patient objects to the disclosure. Your actions in prescribing controlled drugs without a trial of non-pharmacological management were contrary to these guidelines.

Good Medical Practice (2001 edition) applicable at the time, states that;

'Good clinical care must include an adequate assessment of the patient's condition, based on the history and symptoms and, if necessary, an appropriate examination.'

'In providing care you must prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs. You must not give or recommend to patients any investigation or treatment which you know is not in their best interests...'

The GMC also published specific advice on the use of drugs in the treatment of obesity in its newsletter 'GMC News' (winter 1999). Your management of Mr B clearly falls short of the GMC's guidance.

In 2003 the Nutrition Committee of the Royal College of Physicians produced a further document on anti-obesity drugs, in which it is stated that phentermine and diethylpropion are not advocated by the Royal College of Physicians.

The Panel considers that slimming clinics cater for a market of people some of whom are often desperate to lose weight. Sometimes those people are vulnerable and embarrassed because of their weight. They seek easy solutions that offer a 'quick fix' for their weight problems. One thing that can be perceived by patients as being a 'quick fix' is the use of drugs. The two drugs with which this Panel has been particularly concerned are phentermine and diethylpropion. The Panel is in no doubt that your conduct with regard to prescribing to patients, and in particular to Mr B, fell seriously short of accepted standards for the management of overweight and obese persons. Moreover, you have been found to have dispensed diethylpropion without making any real attempt at managing patients with diet or exercise regimes. You also prescribed diethylpropion to a patient with a BMI of 27 with no co-morbidities on their first visit and medication to a patient with a BMI of 26 contrary to accepted good practice.

Another issue of real concern to the Panel was the fact that you knowingly allowed Dr Mostafa Romia to examine patients whose record cards you then signed whilst he was suspended from the Medical Register. He was formally registered as a medical practitioner under the Medical Act 1983. In June 2003 the Professional Conduct Committee found Dr Mostafa Romia conduct had fallen seriously short of the

standard expected in the management of overweight and obese patients and suspended him for a period of nine months. The Panel has heard that he continued to practise after that suspension and his name was subsequently erased from the Register in May 2005.

The Panel considers that, as you knew that Dr Mostafa Romia was suspended at the time you signed patient record cards on his behalf, you did not abide by the guidance contained in GMP. Good Medical Practice at paragraph 26 states:

'You must protect patients from risk of harm posed by another doctor's, or other healthcare professional's, conduct....'

The Panel has carefully considered whether your fitness to practise is impaired by reason of your misconduct, in accordance with Section 35C (2) of the Medical Act 1983, as amended. In doing so it has had regard to the advice provided in the GMC's Indicative Sanctions Guidance. Paragraph 11 states that:

'Neither the Act nor the Rules define what is meant by impaired fitness to practise but for the reasons explained below, it is clear that the GMC's role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practise either with restrictions on registration or at all.'

The Panel took into account paragraphs 57 – 58 in section 3, which give further guidance on the meaning of fitness to practise.

The Panel has determined that, by your acts and omissions, your conduct fell seriously short of the standard expected of a registered medical practitioner and therefore amounts to misconduct. It considers that your misconduct is very serious and, given the breaches of the duties and responsibilities contained in Good Medical Practice, the Panel has found that your fitness to practise is impaired by reason of your misconduct, pursuant to Section 35C (2) (a) of The Medical Act 1983 as amended.