

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 provided medical services at a number of private slimming clinics which were not registered with the appropriate authority. He prescribed drugs, some of which were not recommended for use in the treatment of obesity by either the Royal College of Physicians (RCP) or the British National Formulary (BNF), to a number of patients. He failed to carry out adequate assessments of the patients, did not communicate the risk of side-effects of the drugs, and did not inform the patients' GPs. He also allowed a doctor to dispense drugs at one of the clinics whom he knew to be suspended from the Medical Register.

Relevant paragraphs of *Good Medical Practice*

The case relates to the *Good clinical care* section of GMP, specifically paragraphs 2a, 3b and 3c on providing good clinical care and paragraph 4 on supporting self-care. It also relates to paragraph 13 on keeping up to date in the section on *Maintaining good medical practice*. It also relates to the *Relationships with patients* section, specifically paragraphs 21e on the doctor-patient partnership, paragraph 22b on good communication, paragraph 37 on confidentiality. It also relates to paragraphs 43, 52 and 53 of the section on *Working with colleagues*.

Determination on impaired fitness to practise

“Dr X: The Panel, on [date removed], 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 by reason of your misconduct, pursuant to Section 35C (2) (a) of the Medical Act 1983, as amended. 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. Your solicitor, Mr E, on your behalf, accepted that your conduct in [date removed] will cause great concern to the Panel but that your fitness to practise

should be judged based on your current ability to discharge your duties safely. However, 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 has 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 United Kingdom. From a date known to you until [date removed], on one occasion, you provided or assisted in the provision of medical services at a slimming clinic at XX ("XX Clinic) and at a slimming clinic at YY ("YY Clinic"). You have admitted that 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 ("ZZ 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 AA ("AA Clinic").

You have admitted that 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 the slimming clinics identified above you were aware of, or should have been aware of, the need for the registration of those clinics pursuant to the Care Standards Act 2000. No such registration had in fact been granted. Your provision of medical services at these slimming clinics was inappropriate, unprofessional, and likely to bring the profession into disrepute.

For the purposes of the slimming clinics at XX Clinic, YY Clinic, ZZ Clinic and AA Clinic, you procured and/or obtained medication including diethylpropion and phentermine. 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.

The Panel has found that, between [dates removed], at various times you procured and/or obtained diethylpropion and phentermine for use at clinics operated by Dr Z (or one of his colleagues) at a time when you knew or ought to have known that Dr Z was suspended by the General Medical Council, for dispensing and/or distribution by Dr Z (or one of his colleagues) at a time when you knew or ought to have known that Dr Z was suspended by the General Medical Council.

You have admitted that, on [date removed], inspectors from the National Care Standards Commission visited the XX Clinic. A holdall containing controlled drugs including diethylpropion and phentermine was found on the premises. The drugs found in the holdall belonged to you. In the circumstances controlled drugs, namely diethylpropion and/or phentermine, were not in your control at all times. 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).

You have admitted that, on [date removed], persons authorised by the National Care Standards Commission visited the YY Clinic. A holdall containing controlled drugs including diethylpropion and phentermine was found on the premises. The drugs found in the holdall belonged to you.

The Panel has found that in the circumstances controlled drugs, namely diethylpropion and/or phentermine, were not in your control at all times. 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 [date removed], persons authorised by the Healthcare Commission visited the AA Clinic. Quantities of diethylpropion and phentermine tablets were found in unlocked desk drawers and/or unlocked filing cabinets.

You have admitted that, during a telephone conversation between you and one of the inspectors from the Healthcare Commission on [date removed], you initially stated that the drugs found at the AA Clinic did not belong to you. You stated that, although you had worked at the AA Clinic, you had not been working there for at least 3 weeks prior to that date. You later stated that the drugs found on the premises were yours. You have admitted that you subsequently collected and took away with you all the drugs found on the premises on [date removed].

The Panel has found that in the circumstances controlled drugs, namely diethylpropion and/or phentermine, were not in your control at all times. 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). During the course of the visit on 24 July 2004 by persons authorised by the Healthcare Commission, they found bottles of drugs on the premises. Some of the bottles had labels that did not identify the contents. The labels did not have the address of the clinic on them. The labels did not contain the batch number and/or expiry dates of the medication to which they related. Labels were secured to bottles without a patient name being indicated.

You have admitted that, on dates between [date removed] and [date removed], you saw Mrs A in consultation at the AA Clinic. You did not inform Mrs A's General Practitioner that you were treating her. You did not explain to Mrs A the importance of notifying her GP of the medications she was receiving from the slimming clinic. In exchange for payment, you prescribed diethylpropion to Mrs A, without attempting to help Mrs A to manage her weight with non-pharmacological means prior to prescribing medication, without an adequate medical examination being performed, without providing sufficient information about the nature and side effects of the medication and without adequate monitoring for effects. The Panel has found that you prescribed diethylpropion to Mrs A without a sufficiently detailed medical history being taken.

You have admitted that diethylpropion is not recommended in the BNF or by the Royal College of Physicians in the management of obesity.

The Panel has found that, on a date known to you, you passed to Mrs A, a pile of patient record cards and invited her to find the card containing her details. In doing this, the patient records were not kept securely, or kept in a manner preserving their confidentiality.

You have admitted that, on a number of occasions between [date removed] and [date removed], you saw Mr B in consultation. In [date removed] you saw Mr B in consultation at the ZZ Clinic. Between [date removed] and [date removed] you saw

Mr B in consultation at the AA 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. In exchange for payment, 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 providing sufficient information about the nature and side effects of the medication and without adequate monitoring for effects. You prescribed diethylpropion to Mr B on [date removed] when his blood pressure reading was 161/78, on [date removed] when his blood pressure reading was 153/72, on dates starting from [date removed] until [date removed], during which period his weight increased from 15 stone 10 pounds to 16 stones.

You have admitted that diethylpropion is not recommended in the BNF or by the Royal College of Physicians in the management of obesity. You did not yourself complete the whole prescription for the controlled drug, namely diethylpropion on [date removed] and [date removed].

You have admitted that, on occasions when Mr B attended the AA Clinic and was seen by you, diethylpropion was dispensed to him by Dr Z. From [date removed], Dr Z was suspended from the Medical Register of the General Medical Council. The Panel has found that you caused and/or permitted Dr Z to dispense diethylpropion to Mr B, at the time when you knew or should have known that he was not a registered medical practitioner.

You have admitted that, on dates between [date removed] and [date removed], you saw Mrs C in consultation at the AA Clinic. You did not inform Mrs C's General Practitioner that you were treating her. You did not explain to Mrs C the importance of notifying her GP of the medication she was receiving from the slimming clinic. In exchange for payment, you prescribed diethylpropion to Mrs C, without attempting to help Mrs C to manage her weight with non-pharmacological means prior to prescribing medication, without an adequate medical examination being performed, without providing sufficient information about the nature and side effects of the medication and without adequate monitoring for effects. The Panel has found that you prescribed diethylpropion to Mrs C without a sufficiently detailed medical history being taken.

You have admitted that diethylpropion is not recommended in the BNF or by the Royal College of Physicians in the management of obesity. You prescribed to Mrs C a combination of drugs, which is not in accordance with guidance from the Royal College of Physicians namely Burinex K or bendrofluazide as well as diethylpropion on [date removed], [date removed], [date removed], [date removed], [date removed] and [date removed].

You have admitted that you prescribed to Mrs C Burinex K as well as diethylpropion without seeing her on [date removed], [date removed] and [date removed].

You have admitted that, on dates between [date removed] and [date removed], you prescribed weight control medication to patients who attended the ZZ Clinic and/or the AA Clinic. You prescribed drugs namely diethylpropion and phentermine which are not recommended in the management of obesity. You prescribed drugs to

patients with a BMI of less than 27. You did not always record the patient's pulse, blood pressure, or ensure that adequate monitoring was in place in respect of the effects of such medication. You did not always complete the whole prescription yourself. The Panel has found that you 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 have admitted that you wrote a letter to the General Medical Council which is undated but was received by the General Medical Council on [date removed], in which you state that you had known Dr Z since [date removed] and that you had seen Dr Z 10 to 15 times. You further stated that Dr Z attended the clinic and that his participation during this time was totally administrative with no medical or clinical involvement. In fact you had known Dr Z since before [date removed]. Dr Z had been providing or assisting in the provision of medical services at slimming clinics, as you well knew. You have admitted this conduct was unprofessional. The Panel has found that it was also dishonest and likely to bring the profession into disrepute.

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.

This case concerns your involvement in a number of slimming clinics, which were open for short periods of time and were 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.

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 [date removed], when inspectors from the National Care Standards Commission first visited the clinic at YY, that the clinics that you were working at were not registered under the Care Standards Act 2000. Despite this knowledge, you continued to work at the AA clinic until [date removed].

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

You have admitted a number of shortcomings in relation to your prescribing medication to patients who attended the slimming clinics and in particular Mrs A, Mr B and Mrs C. 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 can 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.

You have admitted prescribing diethylpropion to Ms A, Mr B and Mrs C.

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 obesity or overweightness 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.

Dr W 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 the 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 clinical signs and, if necessary, an appropriate examination. You must prescribe only the treatment, drugs or appliances that serve the patients' needs.’

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 Ms A and 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 who 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 in respect of Ms A and 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.

Another issue of real concern to the Panel was the fact that you knowingly allowed Dr Z 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 [date removed] the Professional Conduct Committee found Dr Z's 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 [date removed].

The Panel considers that, as you did know that Dr Z was suspended at the time you signed patient record cards on his behalf, you therefore did not abide by the guidance contained in GMP.

The Panel has also been referred to paragraph 51 of Good Medical Practice, which states that;

'You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal enquiries. This means that you must take reasonable steps to verify any statements before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information.'

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.

The events which are the subject of the hearing before this Panel took place in [date removed]. Since then you have worked at the BB Clinic in XXXX and have not been subject to any complaint. You have attended courses on obesity and now work as a Specialist Registrar in Chemical Pathology. However, the Panel considers that the catalogue of extremely poor medical practice, coupled with your dishonesty are so serious that, even having regard to what has occurred in the intervening period, the passage of time does not now extinguish your culpability and that your fitness to practise is impaired.”