

## **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 worked outside the limits of his competence, failed to consult with others about the care of three patients, made inadequate records and did not carry out adequate assessments or reviews, nor provide or refer them for appropriate treatment.

### **Relevant paragraphs of *Good Medical Practice***

The case relates to the *Good clinical care* section of GMP, specifically paragraphs 2a, 2b, 2c, 3a, 3b, 3c, 3f, 3g, 3i on providing good clinical care. It also relates to the *Maintaining good medical practice* section, specifically paragraph 12 on keeping up to date. Finally it relates to the *Relationships with patients* section, specifically paragraphs 21b and 21c on the doctor-patient partnership, paragraphs 22a, 22b and 22c on good communication and paragraph 36 on consent.

### **Determination on impaired fitness to practise**

Dr X: The Panel has considered the submissions made by Ms S on behalf of the General Medical Council (GMC) and those by Mr J on your behalf.

At this stage of the proceedings the Panel must decide, under Rule 17 (2) (k) of the General Medical Council (Fitness to Practise) Rules 2004, whether your fitness to practise is impaired.

At all relevant times you were a general practitioner practising from XXXX Surgery, XXXX.

### **Patient Mr BS**

In early December XXXX you were asked to take on Mr BS, a resident of XXXX Nursing Home as one of your patients. You were informed that he suffered from arthritis and psoriasis, was bedridden, suffered bedsores and that there had been problems about his compliance with treatment. Mr BS became registered as your patient on 7 December XXXX. You received Mr BS's medical notes on 20 December XXXX. You did not make contact with Mr BS until 30 January XXXX when you were attending another patient. You did not arrange to return shortly thereafter to make a fuller assessment of Mr BS.

On 25 February XXXX you were informed by XXXX Nursing Home that Mr BS's bedsores were possibly infected. Although you did not visit Mr BS on this occasion, you asked the nursing staff to take swabs for analysis. The results confirmed bacterial infection and you prescribed Erythromycin tablets. However, you did not check whether Mr BS would be able to comply with this medication in tablet form before prescribing.

You next visited Mr BS on 19 March XXXX after being informed by the Home that he was not taking the medication you had prescribed. Mr BS told you that he was not going to take his medication and asked you about the side effects of the drug. You did not visit Mr BS again until 27 May XXXX. On 27 May XXXX you noted that Mr BS had severe pressure sores over the posterior chest wall and a rib was showing through. He would not allow turning by nursing staff. You discussed with him that the pressure sores were potentially life threatening. He agreed to be turned thirty minutes after taking 10mg of morphine sulphate. Mr BS thereafter refused to take the medication.

On 3 June XXXX you were informed by XXXX Nursing Home that Mr BS had deteriorated. You formed the impression that Mr BS was close to death. You did not visit Mr BS. Mr BS died several hours later. The causes of death were 1a. inadequate nutrition, fluid depletion, b. pressure sores, 2. immobility and psoriatic arthritis mutilans.

You failed to provide the requisite standard of care to Mr BS in that you failed to arrange to return shortly after the initial visit on 30 January XXXX to carry out a fuller physical and mental state assessment of Mr BS; you failed to discuss Mr BS, at any time prior to his death, with his previous GP, Dr A; you failed to make a sufficient number of visits to Mr BS between the time of his registration with you and his death; you failed to seek further advice about the management of Mr BS; you failed to involve other specialists in his care; you failed to seek advice about how to deal with Mr BS and you failed to keep clear, accurate and contemporaneous records of your findings and decisions made. These failures were inappropriate, irresponsible, and not in the best interests of the patient.

The GMC's publication 'Good Medical Practice' (May 2001 edition, applicable at the time of these events) states that all patients are entitled to good standards of practice and care from their doctors. It further states that in providing care you must recognise and work within the limits of your professional competence. You should be willing to consult colleagues and keep clear, accurate, legible and contemporaneous patient records which report the relevant findings, the decisions made, the information given to patients and any drugs or other treatment prescribed. Your care of Mr BS did not adhere to these fundamental principles.

The Panel accepts that Mr BS was a difficult patient for any health professional to manage and in many ways he was “unique”. It notes that from an early point in his life he seems to have rejected medical intervention. The Panel also notes that there were problems with the running of the nursing home which impacted upon the level of care available to all residents, including Mr BS. However, the Panel agrees with the views of both the expert witnesses. Dr B, GMC expert witness, was critical of how few visits you made to Mr BS. Dr C, the defence expert witness stated in his evidence that you probably should have visited Mr BS in April XXXX for a further medical assessment. The Panel further notes that it was Dr B’s view, that Mr BS was not terminally ill when he first registered with you. It was your opinion that Mr BS was competent and able to consent with regards to the treatment he required. It is this Panel’s view that you were over-simplistic in your attitude towards Mr BS’s ability to consent to medical treatment. In total you visited Mr BS three times, claiming each visit lasted approximately 15 minutes. This was not enough time, to address the many complex issues involved in the management of Mr BS, particularly when you described yourself as being “shocked” at Mr BS’s physical state when you first saw him on 30 January XXXX.

The Panel is concerned that you still do not appear to have any insight into the decisions you took in respect of Mr BS’s ability to consent. In your oral evidence you stated:

“As far as BS is concerned I still do not feel that I got any of the major decisions wrong as far as mental capacity is concerned, whether he had a mental illness which was sectionable was concerned and the degree to which BS would accept treatment.”

The GMC publication ‘Seeking patients’ consent: the ethical considerations’ (November 1998) paragraphs 1 and 15 state that:

“ Successful relationships between doctors and patients depend on trust. To establish that trust you must respect patients’ autonomy – their right to decide whether or not to undergo any medical intervention even where a refusal may result in harm to themselves or in their own death..... It is for the patient, not the doctor, to determine what is in the patient’s own interests.”

However, it further states in paragraph 26 that:

“Where a patient’s capacity to consent is in doubt, or where differences of opinion about his or her best interests cannot be resolved satisfactorily, you should consult more experienced colleagues and, where appropriate, seek legal advice on whether it is necessary to apply to the court for a ruling.”

The Panel notes that during your evidence you stated that, at the time you were Mr BS’s general practitioner you were not aware of the above GMC publication. However, you stated that you were aware of the legal principles on which it was based. The Panel is of the view that you should have consulted with more experienced colleagues about Mr BS’s care. This would have been in the best interests of Mr BS and yourself. The Panel has found that after you made the decision not to involve other health care professionals in his treatment, you were reactive rather than proactive in the care and treatment of Mr BS.

## **Patient Mrs JT**

On 19 November XXXX you visited Mrs JT at her home following a request for an emergency home visit. Mrs JT had been taken ill whilst out shopping with her daughter Mrs FG. Mrs JT complained of vomiting and dizziness. You were told that Mrs JT had felt dizzy whilst out shopping and she needed to sit down. On her way home she started vomiting and her vomiting continued for some time thereafter.

After examining Mrs JT you told her that you thought that she had suffered a Transient Ischaemic Attack, and that she might have another one. Mrs FG asked you to write down what you had said so that she could tell her brother and sister. You wrote on a piece of paper "Brain Stem Transient Ischaemic Attack (Verto Basillary Insufficiency)". You prescribed anti-sickness tablets. You did not arrange for a review of further blood pressure readings, arrange to carry out standard investigations for dizziness, arrange a follow up visit, or make a referral.

You failed to make any record of the consultation in Mrs JT's medical records. Your action in this regard was inappropriate and not in the best interests of the patient.

The Panel notes that in your evidence you stated that when you visited Ms JT on 19 November XXXX you remember taking her blood pressure and the fact that you did not instigate any treatment or arrange for her to have any follow-up blood pressure readings probably as a result of the blood pressure reading being normal. The Panel has noted the evidence of Dr B, GMC expert witness, who stated that if a diagnosis of a Transient Ischaemic Attack is made then one may decide to do nothing, but it is also important to engage with the patient and family, and to follow-up and check that the patient is "OK". The Panel is concerned that you failed to make a record of the consultation of 19 November XXXX. You stated in your evidence that your usual practice when visiting patients in their homes was to undertake the consultation, go back to your car and then write up the consultation on a continuation sheet and then when you got back to the surgery, ask the receptionist staff to put the continuation sheet in the patients' notes. However, you admitted that whilst this was your usual practice you cannot be certain that you did this in the case of Mrs JT but you considered that it was the most likely thing that could have happened.

The Panel found that in the case of Mrs JT you did not adhere to the principle as set out in The GMC's publication 'Good Medical Practice' (May 2001 edition, applicable at the time of these events) of the need to keep clear, accurate, legible and contemporaneous patient records. The Panel notes that during your oral evidence you accepted that in regards to the three cases being considered by this Panel, Mrs JT, Mr BS and Mr PH, that the standard of your record keeping was "woeful".

## **Patient Mr PH**

Mr PH was allocated to your practice as a patient in XXXX. Mr PH was a long-standing drug user, you first saw Mr PH on 18 June XXXX. At that consultation you

did not take an adequate history, carry out a urine drug screen, contact Mr PH's previous medical practitioner, have sight of his previous medical records nor keep an adequate record of your consultation.

At that consultation you prescribed diazepam 10 mg x 56, temazepam 20 mg x 28 and methadone 490 mls. Your prescribing was inappropriate due to inadequate dose induction for the methadone, and the prescribing of the benzodiazepines on an "as necessary" basis.

On 25 June XXXX Mr PH returned to see you for more medication. You repeated the prescription for benzodiazepines namely diazepam 10 mg x 56 and temazepam 20 mg x 28. On 30 June XXXX Mr PH returned to see you for yet more medication. You prescribed methadone 30 mg – 420 mls, diazepam 10 mg x 56 and temazepam 20 mg x 28. On 2 July XXXX Mr PH returned to see you for more medication claiming he had lost his medication. You again prescribed diazepam 10 mg x 30 and temazepam 20 mg x 28.

Your prescribing on 25 June, 30 June and 2 July XXXX was inappropriate and irresponsible in that you did not

- i. obtain a detailed history,
- ii. obtain a urine drug screen,
- iii. prescribe one benzodiazepine rather than repeating your prescriptions,
- iv. agree treatment goals with PH,
- v. seek help through the local mental health teams, through the local drug dependence service, and/or by consulting with colleagues,
- vi. and keep an adequate record of your consultations.

On 18 August XXXX Mr PH came to see you. You prescribed chlorpromazine initially at a dose of 50 mg nocte but increasing by October XXXX to 150 mg. Your prescribing of chlorpromazine was inappropriate and irresponsible in that you did not make any record in the case-notes to indicate why you prescribed this drug, and you continued to prescribe Chlorpromazine without reference to specialist colleagues.

On 29 October XXXX Mr PH came to see you and you prescribed Lorazepam for him. Your prescribing of this drug was irresponsible in that you failed to take appropriate account of the fact that Mr PH had abused Lorazepam in the past, and you failed to give appropriate consideration to the sedative load on PH given that you were already prescribing diazepam, chlorpromazine and methadone.

On 22 March XXXX Mr PH came to see you. Mr PH complained of enlarged breasts. You stopped prescribing chlorpromazine and prescribed haloperidol 5 mg, despite the fact that it is in the same BNF category as chlorpromazine and has largely the same side effects. On 8 September XXXX you began prescribing olanzapine. Your prescribing of olanzapine was inappropriate and/or irresponsible in that you continued to prescribe it without consulting specialist colleagues until you wrote to

Dr T on 30 September XXXX. You failed to keep an adequate record of your reason for prescribing olanzapine.

Between [date removed] and [date removed, a period of 18 months] you continued to provide treatment for substance misuse and psychosis. During that time your management of Mr PH was inappropriate and irresponsible in that you failed to conduct adequate reviews of Mr PH, failed regularly to involve other professionals and failed to keep adequate records of your consultations. Your actions in relation to Mr PH were inappropriate, inadequate, irresponsible, and not in the best interests of the patient.

The GMC's publication 'Good Medical Practice' (May 2001 edition, applicable at the time of these events) states that in providing care you must recognise and work within the limits of your professional competence and be willing to consult colleagues. In the care of Mr PH you failed to adhere to these principles.

During your evidence you accepted that you were out of your depth treating patient Mr PH. You also stated that when you saw Mr PH for his first consultation, you gave him 35mls of methadone. This was given based on the information which he provided rather than you basing it on any guidelines/guidance. At this time you had not seen Mr PH's medical records and you should have been wary of what you were being told by Mr PH.

Dr B and Dr C, GMC and defence expert witnesses both agreed that it was not appropriate to prescribe benzodiazepines on an "as necessary" basis and that you should have adopted a structured and firm approach when dealing with Mr PH's benzodiazepine addiction.

During the 2 years and 9 months that you were treating Mr PH, you did not follow the guidance as set out in the guidelines published in 1999 "Drug Misuse and Dependence – Guidelines on Clinical Management" which was published by the Department of Health and issued to all general practitioners.

The Panel has considered on the basis of the allegations found proved, whether 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 has borne in mind the contents of paragraph 11 of Section 1 of the Indicative Sanctions Guidance (April 2005), which states that:

"Neither the Act nor the Rules define what is meant by impaired fitness to practise but... 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."

It is the Panel's view that there are clear similarities between your management of the care of patients Mr BS and Mr PH in that in both these cases, you breached fundamental principles as set out in Good Medical Practice. You worked outside the limits of your competence and failed to consult with others about their care. The Panel further notes the link between the cases of Mr BS, Mrs JT and Mr PH in that

they are all characterized by a pattern of inadequate note taking. In all the circumstances, the Panel has determined that your fitness to practise is impaired pursuant to Section 35C (2) (a) of the Medical Act 1983, as amended, by reason of your misconduct.