

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 was Medical Director for a number of private clinics which he did not register with the Healthcare Commission (or its predecessor). The doctor disregarded instructions given by the Healthcare Commission and later the GMC's Interim Orders Panel (IOC) in relation to restrictions on his practice and provided treatment for a patient when his registration was suspended by the IOC and did not inform her of this. When treating several specific patients, he did not carry out adequate assessments, did not give patients enough information about their treatment, did not share information about their treatment with their GPs and did not provide adequate follow-up care.

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. It also relates to paragraph 13 on keeping up to date in the section on *Maintaining good medical practice*. In the *Relationships with patients* section, the case relates to paragraph 21a on the doctor-patient partnership, paragraphs 22b and 22c on good communication, paragraphs 30 and 31 on being open and honest with patients if things go wrong, and paragraph 36 on consent. Finally the case relates to paragraphs 52 and 53 on sharing information with colleagues in the *Working with colleagues* section, and paragraph 59 in the *Probity* section on being honest and trustworthy.

Determination on impaired fitness to practise

At all material times you were the Medical Director for each of these Clinics and were responsible for running them and ensuring compliance with any relevant laws and regulations applicable to them. Medical services were provided at each clinic in respect of which you were required to be registered with the Healthcare Commission, formerly the National Care Standards Commission (NCSC), in accordance with the Care Standards Act 2000 (CSA 2000) and the Private and Voluntary Health Care (England) Regulations 2001 ("the regulations"). In its

determination on the facts, the Panel has given reasons why it has found that you were required to be registered.

On or about [date removed] you were advised of the registration requirements of the NCSC by xxxxxxxxxxxxxx its locality manager. At that time and throughout the dealings you had with the Healthcare Commission, you were not registered in respect of any of your clinics as required.

**Visit by Healthcare Commission Inspectors –
XXXX Clinic, XXXX – [date removed]:**

On [date removed], inspectors from the Healthcare Commission carried out an unannounced visit to your clinic at XXXX Clinic. During the course of that visit the inspectors noted that,

- approximately half the drugs in manufacturers' packs had exceeded their expiry date;
- vaccines were not stored appropriately;

(The Panel clarified that it found this proved in so far as out of date vaccines were stored unsecured on the floor but not proved in relation to flu vaccine on the desk)

- quantities of drugs pre-packed down from bulk were not labelled with expiry dates or batch numbers;
- a syringe had been prepared that was not for immediate use;
- records required to be kept for Phentermine and diethylpropion produced on a pharmaceutical specials licence and supplied to patients were inadequate and written in pencil;
- no controlled drug register was kept for pethidine, a schedule 2 controlled drug found on the premises;
- there was no temperature monitoring of the fridge used to store medicines;
- patient record keeping was inadequate.

The Panel has found that by reason of these matters, except for those of the syringe and the flu vaccine, your management of the clinic was unsafe and inadequate.

During the course of the visit you were served with a Notice of Powers and Rights, issued in accordance with paragraph 5.7 of Code B of the Police and Criminal Evidence Act 1984 (a Code B notice). At the conclusion of the visit the inspectors required you to cease patient treatments with immediate effect. On [date removed], xxxxxxxxxxxxxx wrote to you on behalf of the NCSC setting out the inspectors' findings from their visit and re-iterating that you were required to cease patient treatments with immediate effect; that the restrictions imposed on your practice within the remit of CSA 2000 applied to all of your practice locations; but that consultations with patients carried out on behalf of their employer or another person,

as identified within regulation 4(1)(b) of the regulations, could continue. You were advised to seek legal advice.

Meeting – [date removed]:

On [date removed] you attended a meeting at the NCSC offices to discuss the application process for registration. During that meeting you stated that the services provided by your clinics included weight loss, aesthetic therapies, medical examinations and general medicine; that you were only carrying out consultations and examinations on behalf of third parties; that you were not practising in any areas for which registration under CSA 2000 was required and that other medical practitioners at your clinics were treating patients.

You were advised that an offence may have been committed under the Act by allowing other medical practitioners to treat patients. Further, that treatments to patients at or on behalf of any of your clinics (in the meaning of independent clinic as defined in Section 2 CSA 2000) must cease. You were further advised that evidence of compliance would be sought but that you were not precluded from providing services within the exemptions set out in Regulation 4(1)(b). Following the meeting xxxxxxxxxxxxxxxx wrote to you, on or about [date removed], on behalf of the Healthcare Commission re-iterating these points.

**Visit by Healthcare Commission Inspectors –
XXXX – [date removed]:**

On [date removed], inspectors from the Healthcare Commission carried out a visit to your clinic at XXXX. The inspection established that weight loss and other treatments, for which registration was required under CSA 2000, continued to be provided for patients. This was in breach of the directions previously given to you orally and in writing that treatments for which registration was required, must cease. You were advised that an offence may have been committed by continuing to treat patients whilst unregistered and that treatments to patients for weight loss must stop. You were again issued with a Code B notice. You refused to sign the form. xxxxxxxxxxxxxxxx, on behalf of the Healthcare Commission, wrote to you on or about [date removed], setting out the inspectors' findings from their visit and re-iterating that you had been advised that patients must not be treated save where services were provided under Regulation 4(1)(b), and that carrying out the services of an Independent Clinic without being registered as required might constitute an offence.

**Visit by Healthcare Commission Inspectors –
XXXX Clinic, XXXX – [date removed]:**

On [date removed], inspectors from the Healthcare Commission carried out a visit to your clinic at XXXX. In the course of that inspection you refused to allow the inspectors unfettered access to medical records, and refused to allow copies to be made. They noted that weight loss and other treatments for which registration was required under CSA 2000 continued to be provided; that patients were supplied with weight loss medication without appropriate assessments; that patient records were unclear and inadequate; and that there were discrepancies between the patient records and the pharmacy register. By continuing to provide treatments at your clinic

for which registration was required under CSA 2000, you acted in breach of the directions previously given to you both orally and in writing by the Healthcare Commission. You were issued with a Code B notice that you again refused to sign. Once again, the inspectors told you that you were required to cease treating patients.

On [date removed], you signed a written undertaking that you, XXXX Limited, or anyone acting on your or their behalf, would cease with immediate effect to provide services requiring registration under the Act at any of your clinics or other premises. The Panel accepted that you signed without taking independent legal advice. Contrary to this undertaking you continued to treat patients for weight loss during [date removed].

**Visit by Healthcare Commission Inspectors –
XXXX – [date removed]:**

On [date removed], inspectors from the Healthcare Commission visited your clinic at XXXX. In the course of that visit, you told the inspectors that you no longer provided treatment for the management of obesity, all anti-obesity medication had been disposed of at all clinics, and that you would not stock or supply any drugs listed in Schedules 2 and 3 to the Misuse of Drugs Act, 1971. You admitted that in [dates removed], the Healthcare Commission received information that suggested that you had prescribed temazepam.

On [date removed], inspectors attended your XXXX Clinic for a pre-arranged visit, but were unable to gain access.

On or about [date removed], xxxxxxxxxxxxxx wrote to you on behalf of the Healthcare Commission warning you about obstructing inspectors in their work and advising you that further inspections would be required.

**Visit by Healthcare Commission Inspectors –
XXXX – [date removed]:**

On [date removed], inspectors attended your clinic at XXXX. In the course of their visit, they noted that patient records were incomplete and that, contrary to your previous assertion, weight reducing medication was stored in the safe.

Finding by the Interim Orders Panel [date removed]:

On [date removed], the Interim Orders Panel of the General Medical Council (the GMC), imposed conditions upon your registration. The conditions included:

- you shall limit your medical practice to the practice of occupational health medicine and the carrying out of health assessments for the DVLA,
- should you carry out any other forms of therapeutic medicine or cosmetic treatment not requiring registration with the GMC, then you must not hold yourself out to be permitted to do so by virtue of your registration with the General Medical Council as a medical practitioner,

- you shall comply and co-operate fully with the requirements of the Healthcare Commission,
- you shall not be involved in the provision of treatment for or the management of any patient relating to weight loss,
- you shall keep a record of all patients seen in relation to work carried out as a registered medical practitioner, in the form of a book. This book must contain the name of the patient and the name and contact of the referrer or third party who has arranged for the consultation. This book must be provided to the Panel prior to any subsequent review of the order.

You admitted to this Fitness to Practice Panel that you failed to comply with this final condition imposed upon your registration.

Further dealings with the Healthcare Commission:

The Panel has found that, in a telephone conversation on , with xxxxxxxxx, area team leader for the Healthcare Commission, you made comments that were and were intended to be intimidatory and conducted yourself in a rude and unprofessional manner.

You admitted that on or about [*date removed*] the Healthcare Commission received information that you had issued prescriptions in [*dates removed*] for drugs including diazepam, temazepam and antibiotics.

Visit by Healthcare Commission Inspectors – XXXX – [*date removed*]:

On [*date removed*] inspectors from the Healthcare Commission carried out a visit to your clinic at XXXX. In the course of that visit you admitted that you refused to allow them to see the appointments book; refused to allow them to photocopy notes and shredded or attempted to shred documentation. The Panel has found that you further tried to remove items from the surgery and conducted yourself in a rude, abusive and unprofessional manner. In the course of their visit, inspectors found drugs, including weight-reducing drugs, in a filing cabinet, together with mailing bags.

In its findings of fact, the Panel found proved the allegation quoted in the last sentence. The Panel now wishes to make clear that this finding does not imply a link between the drugs and the bags.

The Panel has found that your breach of the condition imposed by the Interim Orders Panel on XXXX, that you should comply and co-operate fully with the requirements of the Healthcare Commission was unprofessional.

The Panel is seriously concerned that you did not comply and co-operate with the requirements of the Healthcare Commission. It deplores your non-compliance with the requirements of your regulatory body in breaching two of the conditions imposed by the Interim Orders Panel of the GMC.

Matters concerning individual patients

Patients KL

Between [date removed] and [date removed], KL consulted you or one of your medical colleagues at XXXX Clinic, XXXX about weight loss. At these times, KL was of normal body weight. On or about XXXX you supplied KL with a 2 week supply of Tenuate Dospan (diethylpropion – a drug manufactured under a pharmaceuticals specials licence), for which she paid you £26. On or about XXXX you supplied KL with a further two week supply of Tenuate Dospan for which she paid you £26. On or about XXXX, you supplied KL with a two-week supply of Phentermine.

You failed to notify KL's GP of your treatment of her, falsely claiming this was at her request.

On XXXX, KL consulted Dr xxxxxxxxxxxx, an out of hours doctor for Seadoc in XXXX, complaining of chest pains. She disclosed to xxxxxxxxxxxx that she was taking Phentermine, which you had prescribed. xxxxxxxxxxxx wrote to you on three occasions in [date removed] seeking an explanation for your actions. You did not respond to xxxxxxxxxxxx's concerns until [date removed].

As a result of her consultation with Dr xxxxxx, KL re-attended your clinic the next day to complain about your treatment of her. In the course of that meeting you offered KL a choice of further tablets free of charge or a refund and stated that you hoped that you could still be friends. On or about [date removed] you made a lengthy telephone call to KL at her home during which you stated that you had done nothing wrong, that the drugs prescribed were not illegal and that you would lose your practice.

The Panel has found that at all three consultations when you prescribed medication, you failed to provide any or any sufficient information to KL about the drugs; you failed to carry out any or any sufficient assessment of her clinical needs in that you did not take an adequate history, carry out a sufficiently detailed examination and consider sufficiently or at all non-pharmacological methods of weight management. This was irresponsible and not in her best interests. You knew, or should have known that prescribing medicines for weight loss was a registrable activity under CSA 2000. By treating KL in this way for weight loss, you acted in disregard of the instructions given to you orally and in writing by and on behalf of the Healthcare Commission to cease treatments to patients for which registration was required.

Your failure to respond to xxxxxx's letters, your response to KL at the meeting on [date removed] and your telephone call to KL on [date removed] were inadequate, inappropriate and unprofessional. Your failure to notify KL's GP of your treatment of her was irresponsible and not in her best interests. Your false claim that your failure to notify her GP was at KL's request was dishonest.

Patient AP

In [date removed], AP attended your clinic at XXXX Clinic, XXXX for weight loss treatment and was supplied with phentermine. On XXXX, AP's GP, xxxxxxxxxxxxxxxxxx, wrote to the Clinical Governance Lead for XXXX Primary Care Trust raising concerns about her treatment at your clinic.

On XXXX, you telephoned AP at work. In the course of that telephone call you:

- stated that xxxxxxxxxx had made a complaint against you
- asked AP whether she had suffered any side effects from the treatment
- asked AP whether she had been badly treated by the clinic
- asked AP to speak to xxxxxxxxxx to say that she was treated very well and had no side effects
- told AP that you could be “struck off”
- told AP that she had been given wrong information by her GP that phentermine was legal and not dangerous to her health.

The Panel has found that this response to the complaint against you was inadequate, inappropriate and unprofessional and your telephone call to AP was inappropriate.

Patient SS

On [date removed] SS consulted you at your clinic at XXXX Clinic, XXXX about “mole removal,” that is, regarding skin lesions on her neck and body. You treated some of her skin lesions with cryosurgery. Prior to carrying out the treatment you did not provide SS with any or any sufficient information about the procedure, its side effects or aftercare or obtain informed consent. Following the treatment you failed to provide SS with any or any sufficient information about aftercare. You told her that you were too tired to answer her questions about aftercare and that you would e-mail aftercare instructions to her, but failed to do so.

On [date removed] SS consulted you at your clinic at XXXX for further treatment to her skin lesions. Prior to carrying out the treatment, you asked SS to sign a consent form but, following the treatment, you failed to provide sufficient information about aftercare and were dismissive of SS’ concerns about aftercare.

On [dates removed] SS attended her GP’s surgery and sought advice from xxxxxxxxxxxxxx and xxxxxxxxxxxxxx about her skin lesions and the treatment she had received from you. On a date between [dates removed], SS wrote to you setting out her concerns about your treatment of her.

On or about [date removed], SS attended your clinic at the XXXX Clinic with her fiancé, xxxx, to discuss her concerns about the treatment. In the course of this meeting you took a lengthy personal telephone call in their presence and hearing, you sat on a sofa in an almost horizontal posture, did not respond to SS’s concerns in a constructive and open way and conducted yourself in a rude, dismissive and unprofessional manner.

The Panel found that on or about [date removed], you telephoned xxxxxxxxxxxxxx. In the course of that conversation you tried to elicit from xxxxxxxxxxxxxx the clinical details of his treatment of SS, sought to explain your treatment of SS and complained about your treatment by the GMC. The Panel has found that when SS and her fiancé attempted to discuss concerns about your treatment of her, you were

rude, dismissive and unprofessional. Your telephone call to xxxxxxxxxxxx was inappropriate.

Patient ES

On [date removed], ES consulted you at your clinic at the XXXX Clinic about cosmetic treatment to reduce the appearance of lines around her mouth. She sought assurance that you were a qualified doctor and you assured her that you were. One week earlier, on [date removed], the IOP had ordered that your registration be suspended. At no time did you inform ES that you were suspended from medical practice. Despite the fact that cosmetic treatment of this nature does not require medical registration, by failing to inform ES of your suspension you misled ES about your status.

At this first consultation, you recommended a product, Sculptra, to ES. On [dates removed] ES attended appointments at your clinic where you injected Sculptra around her mouth. You did not yourself provide ES with any or any adequate information about the product, potential side effects or aftercare.

On [date removed], ES attended your clinic with concerns about lumps that had developed under the skin at the injection sites. The Panel found that you were dismissive of her concerns and failed to give her an explanation or any advice. In [dates removed], ES re-attended your clinic on two occasions with concerns about lumps that were still present under her skin. On each occasion you injected her with a substance.

You did not explain what you were injecting nor provide any information about the injections to ES. Following the second of these treatments she suffered an adverse reaction.

On [date removed], ES again attended your clinic and asked for her medical notes and information about the treatment provided. You refused to give ES her notes, tell her what had been injected into her face or provide any information about the nature of the injections. In the course of the meeting you acted in an aggressive and intimidating manner.

ES subsequently wrote to you on three occasions requesting her notes. You did not respond to any of her requests. The Panel has found that your lack of response was inadequate, inappropriate and unprofessional.

The Panel is deeply concerned about your management of these patients, which diverged significantly from many of the duties and responsibilities set out clearly in the GMC publication "*Good Medical Practice (2001)*"

In regard to your management of KL, ES and SS you did not adhere to the following:

"In providing care you must:

- keep clear accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed.

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...

Good communication involves:

- giving patients the information they ask for or need about their condition, its treatment and prognosis, in a way they can understand, including, for any drug you prescribe, information about any serious side effects and, where appropriate, dosage.

Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response. This will include an explanation of what happened and where appropriate, an apology. You must not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient."

In relation to all four patients you offended against the duty to:

"treat your patients "politely and considerately."

Good Medical Practice further states that doctors must be honest and trustworthy. Your false claim that KL had requested you not to inform her GP about her treatment offended against this basic principle. Furthermore, in failing to inform ES about your suspension from the Medical Register you misled her about your status.

The Panel has had regard to the submissions of both Counsel on whether your fitness to practise is impaired.

The Panel noted paragraph 11 of the *Indicative Sanctions Guidance* which states:

"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 was referred by Ms N to paragraphs 53 to 55 that state:

- To practise safely, doctors must be competent in what they do. They must establish and maintain effective relationships with patients, respect patients' autonomy...

- But these attributes, whilst essential, are not enough. Doctors have a respected position in society and their work gives them privileged access to patients, some of whom may be very vulnerable. A doctor whose conduct has shown that he cannot justify the trust placed in him should not continue in unrestricted practice while that remains the case.
- In short, the public is entitled to expect that their doctor is fit to practise, and follows the GMC's principles of good practice described in *Good Medical Practice*.

It also states that serious or persistent failures to meet the standards set out in *Good Medical Practice* may put a doctor's registration at risk. These include that a doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients; that a doctor has acted without regard for patients' rights or feelings; and that a doctor has behaved dishonestly or in a way designed to mislead others.

The Panel has heard evidence about your conduct over a period of years and has found proved allegations based on numerous failures in several different areas that offend against the principles in *Good Medical Practice*. It considers that there is a pattern in those failures, namely your wilful disregard of instructions where you felt that they did not or should not apply to you, whether those instructions came from the Healthcare Commission or from the GMC Interim Orders Panel. It considers that you adopted a cavalier approach to prescribing and the storage of medicines which potentially put patients at risk. You disregarded the requirements of the Healthcare Commission, information contained within the British National Formulary, relevant guidelines on the use of medication and concerns expressed by professionals. In addition, there have been findings against you of dishonesty and misleading a patient, and findings of failing to obtain informed consent and of rude, abusive and unprofessional behaviour in relation to a number of patients who wished to discuss your treatment of them.

In the light of the allegations that have been found proved and your numerous, wide-ranging and serious breaches of *Good Medical Practice*, the Panel has determined that your fitness to practise is impaired pursuant to Section 35C(2) by reason of your misconduct.