PUBLISHABLE

General Medical Council

Minutes of the Investigation Committee

Oral hearing on 8 April and 1 May 2026

This hearing was conducted in accordance with the General Medical Council (Fitness to Practise) Rules 2004 (*'The Rules'*).

Name of Doctor	**Dr Amar MOHAMMED**
Doctor's UID	**7045756**

Outcome	Warning
Hearing location:	Held virtually via MS Teams

Committee Members	Mr John Anderson (Chair – Lay)
	Dr Richard Khoo (Lay)
	Dr Nitisha Patel (Medical)

Legal Assessor	Mr David Urpeth
Panel Secretary	Mr Neil Murray

GMC Representative	Ms Fiona McNeill, Counsel
Doctor's attendance	Dr Mohammed attended
Doctor's representative	Mr Elliot Courcha, Counsel

Background

1 On 28 January 2025 the GMC received an online complaint from a pharmacist ('the pharmacist') who raised concerns regarding a patient receiving numerous prescriptions for Mounjaro (a weight loss drug). These prescriptions were dated between December 2024 and January 2025; there was no evidence of a face-to-face consultation, no consent forms and no evidence of the patient's weight or body mass index (BMI).

2 The pharmacist subsequently provided additional information which stated that, whilst all of the prescriptions were issued in Patient A's name, they were delivered to various addresses across the UK. The GMC were provided with further copies of prescriptions for Mounjaro and Kenalog injections (a steroid) made out to Patient A; but, with the delivery details of 8 patients (Patients A-H).

3 These private prescriptions were issued by Dr Mohammed through an online prescribing platform ('the platform') designed to connect aesthetic practitioners with prescribers.

4 On 29 April 2025 the GMC received correspondence from Patient A who confirmed that they were an aesthetics practitioner and had initially ordered the Mounjaro for personal use but had subsequently also ordered it for friends. Patient A confirmed that she was not asked to provide 'medical/consent forms' for her friends.

5 Dr Mohammed is employed by the NHS as a consultant in care of the elderly. His responsible officer confirmed to the GMC that they had no information regarding the matters under investigation, and they did not raise any broader concerns regarding Dr Mohammed's fitness to practise. The GMC also approached Dr Mohammed's current locum placement; they confirmed that they had no concerns regarding his fitness to practise.

6 On 30 June 2025 the GMC received comments from Dr Mohammed via his legal representatives. They explained that, due to a recent relocation, Dr Mohammed was unable to provide any formal consultation records, consent forms or supporting clinical documentation in respect of the prescriptions. His representatives explained that Dr Mohammed was listed as an authorised prescriber on the platform. When prescription requests were submitted by Patient A, Dr Mohammed believed her to be a healthcare practitioner acting on behalf of her clients. It was submitted that Dr Mohammed was entirely unaware that Patient A was requesting the prescriptions for her own personal use; and, for her friends. Dr Mohammed would not have issued the prescriptions if he had been aware of this.

7 His representatives provided screenshots of communication between Dr Mohammed and Patient A on 28 January 2025 and 31 March 2025 in which he explicitly requested details of patient height, weight and BMI prior to processing the prescription request.

8 It was submitted further that no dispensing pharmacy had contacted Dr Mohammed to raise concerns or seek clarification regarding the prescribing pattern and, as such, the absence of

professional dialogue meant that the prescribing continued for longer than it should have done. It was submitted that it was Dr Mohammed's belief that the dispensing pharmacies had access to the relevant consent and medical assessment forms.

9 Dr Mohammed's representatives also highlighted deficiencies in the system used by the platform which allowed prescription requests to be submitted without the provision of consent forms or comprehensive medical documentation. It was submitted that Dr Mohammed had since engaged with the platform to ensure that enhanced safeguards are introduced.

10 His representatives said that Dr Mohammed had ceased all prescribing of Mounjaro via remote platforms. He has commenced an extensive continuing professional development plan which includes safe prescribing, ethics and clinical standards within remote consultations, avoiding prescribing errors and an introduction to telemedicine. In conclusion they submitted that the situation had arisen from exceptional factors including systematic third-party deception and inherent platform limitations that compromised normal clinical oversight.

11 The GMC commissioned the opinion of an independent expert ('the expert'): an experienced consultant physician specialising in the treatment of people with obesity. In their report, dated 18 August 2025, they noted that the specific way in which the platform operated, and what information was visible to Dr Mohammed, had not been established. As such, the expert provided different opinions based upon whether Patient A's or Dr Mohammed's account was accepted.

12 If Patient A's account was accepted the expert opined that the care provided by Dr Mohammed fell seriously below the standard expected in two areas:

I. Failure to undertake consultations with patients, by virtue of:

- Prescribing on the basis of self-completed forms without a direct consultation with any of the patients
- Prescribing without information about BMI
- Not providing information about safety and possible side effects
- Not providing a treatment plan
- Not keeping appropriate clinical records
- Not keeping clinical records securely

II. Inappropriate prescribing

- Dr Mohammed had prescribed inappropriate and excessive quantities of Mounjaro to Patient A which were clearly in excess of their treatment needs and with delivery addresses for other different individuals

13 However, if Dr Mohammed had undertaken clinical consultations, prescribed in accordance with the criteria (i.e based on BMI and any comorbidities), provided information about side effects, and formulated and recorded treatment plans then the care may have been of the standard expected. Similarly, if it accepted that Dr Mohammed was misled by Patient A, and was let down by deficiencies with the platform, he cannot be held responsible for what happened and the care may have been of the standard expected.

14 On 27 August 2025, once the investigation was complete, the GMC wrote to Dr Mohammed under rule 7 of *The Rules* inviting him to comment on the allegations and the evidence that had been gathered before the GMC case examiners made a decision.

15 On 24 September 2025 Dr Mohammed responded, via his legal representative. His representatives provided additional context around what they considered to be systemic shortcomings with the platform and how Dr Mohammed had fallen victim to inappropriate practices of a dishonest user.

16 His representatives provided screenshots which they stated demonstrated that Dr Mohammed was unaware of the different prescription delivery addresses; and, that this was only added at the pharmacy stage. It was noted that the expert recognises that prescribing of weight-loss injections, such as Mounjaro, is often facilitated through questionaries rather than direct consultations. And, whilst the expert considers this approach to fall short of GMC guidance and best practice, it is nonetheless common across commercial providers. As such, Dr Mohammed's conduct should be assessed within a 'sector-wide environment where such practices are routine, rather than as exceptional or wilfully substandard.'

17 It was submitted that all regulatory failures in this matter arise from Patient A's misrepresentation, the design of the platform and commercial sector ambiguity, rather than wilful or reckless misconduct on the part of Dr Mohammed.

18 It was submitted that Dr Mohammed accepts that there was no reliable written or verbal consent for Kenalog or other treatments; and, he relied too heavily on the platform for capturing consent and clinical information. It was submitted further that Dr Mohammed has now implemented a digital, auditable, record-keeping system.

19 Having considered this response, the GMC case examiners concluded that there was no realistic prospect of finding Dr Mohammed's fitness to practise to be impaired and no restriction on his practice would be necessary. They opined that the case could be concluded by issuing a warning.

20 The GMC wrote to Dr Mohammed on 10 November 2025, under rule 7 and 11 of *the Rules*, inviting him to accept the warning proposed by the case examiners and giving him the opportunity to submit representations for their consideration before they made a final decision on the outcome of his case.

21 On 05 December 2025 Dr Mohammed declined to accept the proposed warning and requested that the matter be determined by the Investigation Committee. As such, the case examiners referred the matter of whether a warning should be issued for determination at an oral hearing before this Committee.

22 Notice of this hearing was served on 05 March 2025 and included the particulars of the allegation referred for the Committee's consideration. These are reproduced in full at Annex A of this document.

Evidence adduced

23 The Committee has carefully considered the material before it. The documentary evidence provided by the parties included, but was not limited to:

- Complaint correspondence from Patient A
- A copy of Patient A's medical professional liability insurance policy
- Copies of the prescriptions as set out within Scheule 1-6 of Annex A
- Certificates of completed training and reflective statements from Dr Mohammed
- Patient, colleague and employer feedback provided by Dr Mohammed
- The independent export report obtained by the GMC dated 18 August 2025
- Letter dated 03 September 2024 (sic) from the Co-Founder of the platform confirming that Dr Mohammed ceased prescribing weight loss medication and Kenalog, via their platform, since April 2025
- Screenshots of the platform
- WhatsApp correspondence between Dr Mohammed and the platform's support services
- Employer responses confirming that there were no concerns about Dr Mohammed in respect of his NHS clinical roles.

24 No fitness to practise history was adduced.

GMC Submissions

25 At this hearing, Ms McNeill, on behalf of the GMC submitted that it was an appropriate and proportionate response to issue Dr Mohammed with a warning.

26 Ms McNeill invited the Committee to accept and adopt the opinion of the expert alongside the admitted shortcomings of Dr Mohammed. In respect of allegation 2, which was not admitted by Dr Mohammed, Ms McNeill submitted that the five prescriptions issued between September 2024 and February 2025 amounted to excessive prescribing. The prescriptions were as follows:

- 23 September 2024 – 5mg Mounjaro, 4 doses
- 26 September 2024 – 5mg Mounjaro, 4 doses
- 16 December 2024 – 5mg Mounjaro, 4 doses
- 27 January 2025 - 7.5mg Mounjaro, 4 doses
- 1 February 2025 – 7.5mg Mounjaro, 4 doses

27 Ms McNeill explained that each of the prescriptions were issued in the name, and delivered to the address of, Patient A; and it was the expert's opinion that they were '*clearly in excess of Patient A's treatment needs*.'

28 In respect of Dr Mohammed's submissions prior to this hearing, Ms McNeill referred to the expert's confirmation that a prescriber is not relieved of their responsibilities under *Good medical practice* (and the more detail guidance on prescribing) by any flaws in the platform or any misrepresentations from the patient.

29 Ms McNeill submitted that Dr Mohammed's actions did not meet with the standards required of a doctor. They risked bringing the profession into disrepute and must not be repeated. The required standards are set out in *Good medical practice* and associated guidance. In this case, paragraph 6, 9, 69 and 81 of *Good medical practice (2024)* are particularly relevant alongside paragraph 19 of *Good practice in proposing, prescribing, providing and managing medicines and devices (2021).*

30 Ms McNeill submitted that the breaches of these paragraphs were clear; and, that those breaches risked patient safety and risked bringing the profession into disrepute. Whilst these failings are, in themselves, not so serious as to require any restriction on Dr Mohammed's registration, it is necessary in response to issue a formal warning. It was submitted further that if the behaviour was to be repeated it would more than likely result in a conclusion that Dr Mohammed's fitness to practise was impaired.

31 In respect of the guidance on whether a warning is required, Ms McNeill referred the Committee to the factors set out in paragraph 15 of the guidance. She acknowledged that Dr Mohammed has no relevant fitness to practise history and has demonstrated a degree of insight and remediation. However, Ms McNeill also submitted that Dr Mohammed's insight and remediation was in response to concerns being raised and that the incidents occurred over a period of time. Further, that question marks remain over Dr Mohammed's claims regarding Patient A, and his claim regarding the loss of his consultation records.

32 Ms McNeill submitted that Dr Mohammed's actions had the potential to directly affect patients, undermine public confidence and trust in medical professionals and undermine the reputation of the profession. Greater weight should be attributed to the seriousness of the conduct and the importance of maintaining public trust in the profession, rather than the impact of any response on the doctor.

33 Ms McNeill said that it would be appropriate to mark Dr Mohammed's actions as unacceptable in order to declare and to uphold the proper standards of conduct for the profession; and, as such, it would be appropriate for the Committee to impose a warning.

Defence Submissions

34 Mr Courcha, on behalf of Dr Mohammed, clarified that the platform connects practitioners to authorised prescribers. The practitioner is an individual who is registered with the platform as having appropriate qualifications to perform certain treatments, usually aesthetic treatments. To register with the platform, practitioners have to go through a verification process which includes providing certificates as proof that they have undergone the requisite training.

35 Mr Courcha explained that, although the practitioners are qualified to perform certain treatments, they cannot prescribe medication and therefore rely on being linked to an authorised prescriber through the platform. Dr Mohammed was one such authorised prescriber. Authorised prescribers are not undertaking the primary contact with patients or clients; and they are not generating the prescriptions. They are simply reviewing them, reviewing their appropriateness and signing them off once they are satisfied that they are clinically indicated.

36 Mr Courcha said that Dr Mohammed's contact with Patient A was in her capacity as a registered practitioner on the platform and that he had relied on Patient A having the requisite training to request prescriptions for authorisation. Mr Courcha drew the Committee's attention to a copy of Patient A's medical professional liability insurance; which, he submitted, goes to the fact that Patient A was registered as a practitioner on the website, rather than her being an individual patient requesting prescriptions. Further, it can be seen on the prescriptions that the fields for 'Practitioner' and 'Patient' both contained Patient A's name and, whilst the delivery address was for different individuals, Dr Mohammed would not have known this at the time of authorising the prescription.

37 He also referred to Dr Mohammed's WhatsApp messages, which asked for the height of Patient A's '*client*', and submitted that these messages are demonstrative of Dr Mohammed's belief that the prescriptions were not for Patient A's personal use.

38 In respect of whether Dr Mohammed began requesting BMI information before or after being made aware of the GMC investigation, Mr Courcha noted that the WhatsApp messages of 28 January 2025 and 31 March 2025 predated the GMC disclosing the existence of its investigation.

39 Mr Courcha also drew the Committee's attention to a prescription request dated 24 October 2024, which contained a box titled 'prescription summary' which states:

> *'no data available as medical form has not been completed, we will send a request to the client's email to complete the medical form and we will automatically attach it to the prescription once they have completed it'*

He submitted that this provided further evidence of Dr Mohammed's reliance on the platform's safeguards.

40 In respect of the allegations before the Committee Mr Courcha, on behalf of Dr Mohammed, admitted allegation 1 and allegations 3 through 17, albeit acknowledging the surrounding context and potential mitigating factors. Allegation 2 was denied.

41 In respect of this allegation, Mr Courcha submitted that the independent expert may have confused the different platforms and did not completely recognise the fact that Patient A was a practitioner, and that is why the requests were all submitted in her name. An examination of the prescriptions where Patient A is named as the recipient of the medication, shows there are only five prescriptions spaced across a number of months. Mr Courcha submitted that an objective assessment of these prescriptions would indicate that they are not excessive.

42 Mr Courcha submitted that some of the prescriptions appear to close together because there were shortages of stock at that time. This is evidenced by the prescription dated 26 September 2024 which includes the following note: *'Please remember to charge £1. Thank you'.* This, Dr Mohammed has explained, is a nominal fee that was charged where a prescription was reissued because a previous prescription was unfulfilled due to stock issues.

43 Mr Courcha said that is unclear why these specific prescriptions have been identified as representing excessive prescribing of Mounjaro. He referred to the independent expert's opinion that *'the changing drug doses prescribed to each of the named individuals often show expected monthly dose escalations or continuation at specific maintenance dose'*. While the expert went on to state that there was excessive prescribing in respect of Patient A this was, Mr Courcha said, because the expert has not recognised the fact that Patient A was a practitioner requesting the medication on behalf of others.

44 Regarding the test for whether a warning should be issued, Mr Courcha said that Dr Mohammed recognises the GMC's concerns, but they are capable of being remedied and he has taken the necessary steps to do so. Mr Courcha submitted that regulatory action is not required.

45 He referred the Committee to paragraph 15 of the guidance *Decision on whether a warning is required,* which set out the factors that will inform the Investigation Committee's decision. Mr Courcha submitted that Dr Mohammed has no relevant fitness to practise history and an unblemished 15-year career in medicine. The concerns are discreet: they relate solely to requests by a single user, Patient A. Mr Courcha said that, whilst Dr Mohammed did not seek to hide behind the failures of the platform or any deception from Patient A, it was important to recognise that the concerns are not representative of Dr Mohammed's standard use of the platform or broader practice.

46 Mr Courcha said that Dr Mohammed acknowledges that his reliance on the platform's safeguards, and the absence of retained contemporaneous records, falls below the standard

expected standard of him. The following paragraph from Dr Mohammed's reflective statement was highlighted:

> *"I wish to begin this reflective summary by acknowledging in full the concerns raised by the GMC and the findings of the expert report. I recognise that my prescribing decisions through the [the platform] did not consistently meet the high standards rightly expected of me as a doctor. While my actions were taken in good faith, I accept my reliance on platform safeguards and information provided by a practitioner was not sufficient and that the responsibility for safe prescribing always rests with me."*

47 Mr Courcha submitted that the risk of repetition was negligible. Dr Mohammed has shown an extremely strong sense of accountability which has been evidenced by his genuine reflections and remediation. This included re-training, ceasing all work with the platform and engaging with them to make improvements to their systems to support safer prescribing.

48 In respect of Dr Mohammed's inability to provide records in respect of his prescribing to Patient A, Mr Courcha said that Dr Mohammed has introduced a new digital record system, ensuring every consultation is fully documented in real time.

49 In respect of proportionality, Mr Courcha invited the Committee to consider what is required to achieve public protection and no more. In light of the context in which the concerns arose, the significant insight and remediation and the negligible risk of repetition, a warning would be disproportionate.

Legal advice

50 Mr Urpeth noted that all allegations save for allegation 2 have been admitted. It has not been contended that the matter should be referred for consideration before a Medical Practitioners Tribunal, nor has it been contended that anything has emerged in the course of the evidence before the Committee that would render such a course appropriate.

51 Mr Urpeth reminded the Committee of its powers under rule 11(6), its task today and the purpose of issuing a warning. He reminded it that the question of the warning, and the terms of any warning issued, are matters for the Committee's own discretion and that it is not restricted by the outcome proposed by the GMC case examiners.

Committee Determination

52 The Committee thanked Dr Mohammed for his attendance and both Counsel for their submissions. It accepted the independent advice provided by the legal assessor on the approach to be adopted.

53 The role of the Committee is to consider whether a warning is both appropriate and proportionate. It considered this matter afresh; it did not have sight of the case examiners' reasoning.

Determination on the facts

54 In light of Dr Mohammed's response to the allegations, the Committee found allegation 1 and allegations 3 through 17 admitted and found proven. Therefore, the only allegation in dispute, and which required a finding by the Committee, was allegation 2. Namely, that on the dates set out in Schedule 2 (see Annex A) Dr Mohammed inappropriately prescribed excessive Mounjaro to Patient A.

55 The Committee was satisfied that the evidence before it was sufficient to conclude, on the balance of probabilities, that the prescriptions occurred on the dates set out in Schedule 2 and that they were inappropriate and excessive.

56 In reaching this conclusion the Committee relied upon the absence of any evidence that Dr Mohammed consulted with Patient A to assess whether there was an initial clinical need for a prescription of Mounjaro, including no evidence as to Patient A's BMI. Similarly, there is no evidence that Dr Mohammed reassessed Patient A prior to subsequent prescriptions and increasing the dose of Mounjaro.

57 The Committee further relied upon the opinion of the independent expert who confirmed that the different drug doses were 'clearly in excess of Patient A's treatment needs' and that this element of care fell seriously below the GMC's standards for prescribing.

58 The defence submission that an objective assessment of Patient A's prescriptions would indicate that they are not excessive was rejected. This was on the basis of the Committee's preference for the expert evidence, and its own assessment of the chronology of the prescriptions issued.

Committee's decision on a warning

59 Throughout its deliberations the Committee had regard to the GMC guidance *Decision on whether a warning is required*, which states that a warning will be appropriate where a doctor's conduct has fallen significantly below the professional standards expected to a degree warranting a formal regulatory response. This is the test that the Committee must apply.

60 In accordance with the guidance, the Committee first considered whether Dr Mohammed's conduct constituted a clear and specific departure from the standards expected of a doctor and, if similar behaviour was repeated, whether it would likely result in a conclusion that his fitness to practise is impaired.

61 The Committee found that Dr Moahmmed's prescribing of Mounjaro constituted a clear and specific departure from the standards expected of a doctor, most notably:

Good medical practice (2024)

6 *You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options.*

9 *You must provide safe and effective clinical care whether face to face, or through remote consultations via telephone, video link, or other online services. If you can't provide safe care through the mode of consultation you're using, you should offer an alternative if available, or signpost to other services.*

69 *You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.*

81 *You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.*

Good practice in proposing, prescribing, providing and managing medicines and devices (2021)

19 *You should only propose, prescribe or provide medicines treatments and devices if you have adequate knowledge of the patient's health, and you are satisfied that the medicines serve the patient's needs. You must consider:*

1. the suitability of the mode of consultation you are using, for example face to face or remote, taking account of any need for physical examination or other assessments

2. whether you have sufficient information to prescribe safely, for example if you have access to the patient's medical records and can verify relevant information

3. whether you can establish two-way dialogue, make an adequate assessment of the patient's needs and obtain consent whether you can share information appropriately after an episode of care.

62 In making this finding the Committee relied upon the evidence of the independent expert who had confirmed the standards to be expected and the ways in which Dr Mohammed failed to undertake appropriate consultations and had prescribed inappropriately. The Committee accepted the expert's opinion that Dr Mohammed's actions, and omissions, fell seriously below the standards to be expected of a doctor prescribing remotely.

63 The Committee is satisfied that if the same, or a similar, incident reoccurred, this would likely result in a conclusion that Dr Mohammed's fitness to practise is impaired.

64 This was therefore a case where a warning may be required. Although a warning would not prevent Dr Mohammed from holding a licence to practice, it would be a serious regulatory response that would serve to remind him that any repetition is likely to result in a finding of impaired fitness to practise and restrictions being placed on his practice.

65 There were a number of factors present that weighed in Dr Mohammed's favour and against a warning being required. These were that he has no relevant fitness to practise history, he has expressed genuine regret, and he has reflected at length upon his conduct. Indeed, there was evidence of targeted remediation in respect of remote prescribing. Dr Mohammed has also ceased working for the platform and has sought to resolve perceived deficiencies within it.

66 However, Dr Mohammed continued to ascribe fault to others, notably Patient A and the platform itself, rather that accepting that he ultimately bore responsibility as the person prescribing the medication.

67 The Committee found it concerning that Dr Mohammed continued to prescribe Mounjaro for Patients A-H over a prolonged period of time, and that he repeatedly prescribed without carrying out consultations. The Committee was also concerned as to the breadth of the failings which contributed to the failure to undertake consultations, which included prescribing on the basis of self-completed questionnaires, without information as to the patients' BMI and failing to provide information about safety and possible side effects. In addition, the Committee found that not documenting appropriate records, and Dr Mohammed's failure to securely store clinical records, was troubling.

68 On balance, whilst there are a number of factors in your favour, due to the severity of the failings, and elements of concern detailed above, the Committee has determined a warning may be required.

69 Notwithstanding that Dr Mohammed's conduct had fallen significantly below the standards expected of a doctor and a warning may be required in regard to any repetition of this, the Committee was mindful that a warning must be proportionate.

70 In reaching its decision on whether a warning would be proportionate in the circumstances of this case, the Committee had regard to the GMC's legal duty to protect the public. The Medical Act 1983 splits this duty into three distinct parts and requires the GMC to act in a way that:

- protects, promotes and maintains the health, safety and wellbeing of the public ('patient safety')
- promotes and maintains public confidence in the profession
- promotes and maintains proper professional standards and conduct for members of the profession.

71 Warnings are issued in the interests of maintaining public confidence in the profession and upholding professional standards. In addition to warning a doctor regarding their future

behaviour, they also highlight to the wider profession and public that certain behaviour or poor performance is not acceptable.

72 In light of the breaches identified, the Committee considered that a warning would fulfil each of the three distinct parts of the GMC's legal duty to protect the public in that a warning would protect patient safety, promote maintain confidence in the profession and promote and maintain professional standards. The Committee sought to balance this against Dr Mohammed's interests but considered the need to protect the public outweighed the impact a warning may have upon Dr Mohammed.

73 In conclusion, the Committee determined that Dr Mohammed's conduct has fallen significantly below the expected standards and that a warning would be an appropriate and proportionate response. The Committee issued Dr Mohammed with the following warning:

On multiple occasions between 23 September 2024 and 25 January 2025, Dr Mohammed inappropriately prescribed Mounjaro, without either undertaking an appropriate consultation or without having sufficient clinical information to prescribe safely.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice and Good practice in proposing, prescribing, providing and managing medicines and devices. In this case, the following paragraphs of these guidance documents are particularly relevant:

Good medical practice (GMP):

> ***6** You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with them to assess their needs and priorities. The investigation or treatment you propose, provide or arrange must be based on this assessment, and on your clinical judgement about the likely effectiveness of the treatment options.*
>
> ***9** You must provide safe and effective clinical care whether face to face, or through remote consultations via telephone, video link, or other online services. If you can't provide safe care through the mode of consultation you're using, you should offer an alternative if available, or signpost to other services.*
>
> ***69** You must make sure that formal records of your work (including patients' records) are clear, accurate, contemporaneous and legible.*
>
> ***81** You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession.*

Good practice in proposing, prescribing, providing and managing medicines and devices:

19 *You should only propose, prescribe or provide medicines treatments and devices if you have adequate knowledge of the patient's health, and you are satisfied that the medicines serve the patient's needs. You must consider:*

1. the suitability of the mode of consultation you are using, for example face to face or remote, taking account of any need for physical examination or other assessments

2. whether you have sufficient information to prescribe safely, for example if you have access to the patient's medical records and can verify relevant information

3. whether you can establish two-way dialogue, make an adequate assessment of the patient's needs and obtain consent whether you can share information appropriately after an episode of care

Whilst this failing in itself is not so serious as to require any restriction on Dr Mohammed's registration, it is necessary in response to issue this formal warning. This warning will be published on the medical register in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy .

That concludes the determination of the Investigation Committee in this case.

Annex A

GMC reference number: 7045756

Patient A

1. On, the dates set out in Schedule 1, Dr Mohammed failed to undertake consultations with Patient A in that he:

    a. prescribed on the basis of a self- completed questionnaire;

    b. prescribed without information about Patient A's body mass index (BMI);

    c. did not provide information about safety and possible side effects;

    d. failed to implement an adequate treatment plan;

    e. failed to maintain an adequate record of these consultations;

    f. failed to keep clinical records securely.

2. On, the dates set out in Schedule 2, Dr Mohammed inappropriately prescribed excessive Mounjaro to Patient A.

3. In the alternative to paragraphs 1a -1d, he failed to record having undertaken the actions outlined.

Patient B

4. On, the dates set out in Schedule 3, Dr Mohammed failed to undertake consultations with Patient B in that you:

    g. prescribed on the basis of a self- completed questionnaire;

    h. prescribed without information about Patient B's BMI;

    i. did not provide information about safety and possible side effects;

    j. failed to implement an adequate treatment plan;

    k. failed to maintain an adequate record of these consultation;

    l. failed to keep clinical records securely.

5. In the alternative to paragraphs 4a -4d, you failed to record having undertaken the actions outlined.

Patient C

6. On, the dates set out in Schedule 4, you failed to undertake consultations with Patient C in that you:

    a. prescribed on the basis of a self- completed questionnaire;

    b. prescribed without information about Patient C's BMI;

    c. did not provide information about safety and possible side effects;

    d. failed to implement an adequate treatment plan;

    e. failed to maintain an adequate record of these consultation;

    f. failed to keep clinical records securely.

7. In the alternative to paragraphs 6a -6d, you failed to record having undertaken the actions outlined .

Patient D

8. On 24 October 2024, you failed to undertake a consultation with Patient D in that you:

    a. prescribed on the basis of a self- completed questionnaire;

    b. prescribed without information about Patient D's BMI;

    c. did not provide information about safety and possible side effects;

    d. failed to implement an adequate treatment plan;

    e. failed to maintain an adequate record of this consultation;

    f. failed to keep clinical records securely.

9. In the alternative to paragraphs 8a -8d, you failed to record having undertaken the actions outlined.

Patient E

10. On, the dates set out in Schedule 5, you failed to undertake consultations with Patient E in that you:

    a. prescribed on the basis of a self- completed questionnaire;

    b. prescribed without information about Patient E's BMI;

c. did not provide information about safety and possible side effects;

d. failed to implement an adequate treatment plan;

e. failed to maintain an adequate record of these consultation;

f. failed to keep clinical records securely.

11. In the alternative to paragraphs 10a -10d, you failed to record having undertaken the actions outlined.

Patient F

12. On 4 February 2025, you failed to undertake a consultation with Patient F in that you:

a. prescribed on the basis of a self- completed questionnaire;

b. prescribed without information about Patient F's BMI;

c. did not provide information about safety and possible side effects;

d. failed to implement an adequate treatment plan;

e. failed to maintain an adequate record of this consultation;

f. failed to keep clinical records securely.

13. In the alternative to paragraphs 12a -12d, you failed to record having undertaken the actions outlined.

Patient G

14. On 1 March 2025, you failed to undertake a consultation with Patient G in that you:

a. prescribed on the basis of a self- completed questionnaire;

b. prescribed without information about Patient G's BMI;

c. did not provide information about safety and possible side effects;

d. failed to implement an adequate treatment plan;

e. failed to maintain an adequate record of this consultation;

f. failed to keep clinical records securely.

15. In the alternative to paragraphs 14a -14d, you failed to record having undertaken the actions outlined.

Patient H

16. On, the dates set out in Schedule 6, you failed to undertake consultations with Patient H in that you:

    a. prescribed on the basis of a self- completed questionnaire;

    b. prescribed without information about Patient H's BMI;

    c. did not provide information about safety and possible side effects;

    d. failed to implement an adequate treatment plan;

    e. failed to maintain an adequate record of these consultation;

    f. failed to keep clinical records securely.

17. In the alternative to paragraphs 16a -16d, you failed to record having undertaken the actions outlined.

Schedule One

23 September 2024

26 September 2024

16 December 2024

27 January 2025

1 February 2025

Schedule Two

23 September 2024

26 September 2024

16 December 2024

27 January 2025

1 February 2025

Schedule Three

26 September 2024

30 October2024

24 November 2024

14 December2024

21 January 2025

25 February 2025

Schedule Four

31 December2024

23 January 2025

5 February 2025

6 February 2025

Schedule Five

24 November 2024

26 December 2024

4 October 2024

27 January 2025

24 February 2025

Schedule Six

9 January 2025

14 February 2025