PUBLIC RECORD

Dates: 09/12/2024 - 17/12/2024

Doctor:	Dr Bijal Mahendra TRIVEDI
GMC reference number:	6077502
Primary medical qualification:	MB BS 2003 University of London

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired
XXX	XXX	XXX

Summary of outcome

XXX
XXX

XXX

Tribunal:

Legally Qualified Chair	Ms Amarjit Sagar
Lay Tribunal Member:	Mrs Jane Johnson
Medical Tribunal Member:	Dr Bridget Langham

Tribunal Clerk:	Mr John Poole

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Simon Cridland, Counsel, instructed by Weightmans LLP
GMC Representative:	Mr Terence Rigby, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in private.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts and Impairment - 16/12/2024

Facts

1. This determination will be handed down in private XXX. However, as this case also concerns an allegation of misconduct, a redacted version will be published at the close of the hearing.

Background

2. Dr Trivedi qualified in 2003 from the University of London and went on to have a mixed medical and academic career in Australia and the UK up to 2014. He then worked for a company called 'Kool Pharma' writing prescriptions until 2016. In 2020, Dr Trivedi started training in General Practice in Hull. At the time of the events that form the subject of this hearing, he was employed by Hull University Teaching Hospital NHS Trust as a General Practice Trainee. Dr Trivedi has not worked as a doctor since the matters that give rise to this hearing, which relate to an Allegation of impairment by reason of misconduct XXX.

Misconduct

3. By way of background to the misconduct allegation pertaining to Dr Trivedi's involvement with Patient B, Dr Trivedi's first contact with Patient B was on 16 December 2021 when he had been asked by Dr A to provide a repeat prescription of ADHD medication, Methylphenidate, for Patient B. Dr Trivedi had a telephone consultation with Patient B during which the appropriateness of Methylphenidate was discussed along with other alternative medications, including Atomoxetine.

4. Also by way of background to the prescribing concerns outlined in the allegation, on 9 April 2021, Dr Trivedi received a warning in relation to his prescribing medications as an employee of Kool Pharma, when he did not have the appropriate training or experience.

5. It is alleged that on 17 January 2022, Dr Trivedi took a blank prescription sheet belonging to his clinical supervisor Dr A, without permission, and prescribed 18mg Atomoxetine for Patient B when he did not have the requisite training and/or experience to do so, which was not clinically justified, and had the potential to cause Patient B harm.

6. It is further alleged that Dr Trivedi failed to consult Patient B at all before prescribing the medication, and failed to discuss changing Patient B's medication with his clinical supervisor, Dr A. It is also alleged that on 18 January 2022, Dr Trivedi attended Boots pharmacy to collect the medication and failed to complete the back of the prescription form in that he did not sign the prescription or check the box which read '*on behalf of the patient*'. Further, that he failed to inform the pharmacy staff that he was collecting the medication on behalf of Patient B.

7. On 18 January 2022, Patient B received a text from a Boots Pharmacy, which was not a pharmacy he used. Out of curiosity Patient B telephoned the pharmacy and was informed by an employee that someone had just been in to collect a prescription for him that he had left the previous day. During the same conversation Patient B was informed that the employee had asked if the man wanted repeat prescriptions, he had said yes and had also written Patient B's telephone number on a piece of paper. Patient B was so concerned about the prescription of Atomoxetine in his name that he sent an email to Dr A on the evening of 18 January 2022. Thereafter, he became increasingly anxious about the situation and the investigation that followed.

8. Upon being informed by Patient B of what had happened, Dr A asked Dr Trivedi about the prescription when he next saw him on 19 January 2022. Dr A showed Dr Trivedi the email from Patient B and asked if he had given any other prescriptions to Patient B other than the repeat prescription of Methylphenidate on 16 December 2021. Dr A asked Dr Trivedi more than once and he denied it each time. Dr A noted that Dr Trivedi was anxious and 'not himself.'

9. On 21 January 2021, Dr A received a text from Dr Trivedi saying:

'XXX'

10. In his witness statement, Dr A stated that at a meeting on 26 January 2022:

'Dr Trivedi was tearful and admitted that he had written and collected the prescription. XXX. His rationale was that it was not right or safe that Patient B be prescribed a medication that could cause disturbing thoughts and so he changed the medication to Atomoxetine" and "He also admitted that he had taken one page from the prescription pad while I had been at reception with a patient.''

11. It is alleged that Dr Trivedi's fitness to practise is impaired by reason of misconduct.

12. XXX

XXX

13. XXX

14. XXX

15. XXX

16. XXX

The Outcome of Applications Made during the Facts Stage

17. The Tribunal granted an application made by Mr Rigby, on behalf of the GMC, to amend paragraph 2a of the Allegation. Mr Rigby submitted that the actual allegation is that Dr Trivedi took a prescription sheet and not the whole prescription pad as it currently would appear from the wording of the allegation and as such, this should be clarified. Mr Cridland did not oppose the application and agreed and proposed the amendment to read '*took a blank prescription sheet…'* The Tribunal agreed the amendment could be made without injustice to either party and therefore granted the application in accordance with Rule 17(6) of the of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules')

18. The Tribunal determined that the hearing be held entirely in private XXX. It considered that it would be impractical to try to manage the hearing by going in and out of private and that there would be a real risk of private matters inadvertently being discussed whilst in public session. The Tribunal determined that the hearing should be held in private in fairness to Dr Trivedi. Further, it was in the public interest for the hearing to be managed efficiently and there would be a redacted version of the Tribunal's determinations after the hearing, XXX. Parties endorsed this approach. Accordingly, the Tribunal determined that the hearing be held in private in accordance with Rule 41 of the Rules.

The Allegation and the Doctor's Response

19. The Allegation made against Dr Trivedi is as follows:

1. On 9 April 2021, you were given a warning by the GMC as set out in Confidential Schedule 1. Admitted and found proved

2. Between 4 August 2021 and 1 February 2022, you were employed by Hull University Teaching Hospitals NHS Trust as a General Practice Trainee, and on or around 17 January 2022, you:

    a. took a blank prescription ~~pad~~ sheet belonging to your clinical supervisor Dr A, without permission; Admitted and found proved

    Amended in accordance with Rule 17(6) of the Rules

    b. prescribed 18mg Atomoxetine ('the Medication') for Patient B:

i. when you did not have the requisite training and/or experience to do so; **Admitted and found proved**

ii. which:

1. was not clinically indicated; **Admitted and found proved**

2. had the potential to cause Patient B harm; **Admitted and found proved**

c. failed to consult Patient B at all before prescribing the Medication; **Admitted and found proved**

d. failed to discuss changing Patient B's medication with your clinical supervisor, Dr A. **Admitted and found proved**

3. On 18 January 2022, you attended Boots pharmacy to collect the Medication and you failed to:

a. complete the back of the prescription form, in that you did not:

i. sign the prescription; **Admitted and found proved**

ii. check the box which read 'on behalf of the patient'; **Admitted and found proved**

b. inform the pharmacy staff that you were collecting the Medication on behalf of Patient B. **Admitted and found proved**

4. XXX

5. XXX

And that by reason of the matters set out above your fitness to practise is impaired because of your:

a. misconduct in respect of paragraphs 1-3; **To be determined**

b. XXX

The Admitted Facts

20. At the outset of these proceedings, through his counsel, Mr Cridland, Dr Trivedi admitted to the entirety of the Allegation, as amended, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Impairment

21. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out above, Dr Trivedi's fitness to practise is impaired by reason of misconduct XXX.

The Evidence

22. XXX

23. XXX

24. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Dr A: Consultant Psychiatrist, he had been Dr Trivedi's clinical supervisor during his placement with him as a GP trainee;
- Patient B

25. Dr Trivedi provided his own witness statement, dated 7 November 2024 and also gave oral evidence to the Tribunal.

26. The Tribunal also received expert evidence from Dr C, General Practitioner, who provided a report dated 4 December 2023.

27. Dr C identified a number of actions taken by Dr Trivedi on 17 and 18 January 2022, which he opined to be seriously below the standard to be expected of a reasonably competent GP ST2. Referring to GMP, Dr C stated, *'these failings related to fundamental aspects of medical practice, namely: working within your field of competence, working in partnership with patients, working collaboratively with colleagues and ensuring that documents are accurate and not misleading.'*

Documentary Evidence

28. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Previous MPT determination on impairment and determination to issue a warning, dated 9 April 2021;
- XXX;
- Various correspondence relating to the internal trust investigation pertaining to the incident regarding the prescription written for Patient B;
- A stage two bundle provided in support of Dr Trivedi, including a statement dated 10 December 2024, various reflections, Colleague Feedback and CPD certificates.

Submissions

29. Both parties provided detailed written submissions upon which they elaborated orally.

GMC Submissions

30. On behalf of the GMC, Mr Rigby submitted that Dr Trivedi's fitness to practise is impaired by reason of misconduct XXX.

31. In his written submissions, he outlined the relevant legal framework to be followed at this stage.

32. Mr Rigby submitted that the Tribunal must consider whether Dr Trivedi's actions amount to serious misconduct and whether his fitness to practise is impaired by reason of serious misconduct XXX.

33. XXX

34. Mr Rigby took the Tribunal through what he submitted were the undisputed facts of the case.

35. Mr Rigby submitted that on 16 December 2021 Dr Trivedi was instructed to provide a repeat prescription for Patient B and took it upon himself to consult the patient about his conditions and alternative medications, including Atomoxetine. Mr Rigby submitted that Dr Trivedi overstepped his role to some degree at least by consulting with Patient B and suggesting there were alternative medications which he could prescribe for him. Mr Rigby submitted that Dr Trivedi's subsequent actions could be seen as the culmination of that consultation.

36. XXX

37. XXX

38. Mr Rigby submitted that Dr Trivedi went to work on 17 January 2022 and completed his work XXX. Mr Rigby submitted that what Dr Trivedi did do, was surreptitiously take a prescription sheet from Dr A's pad and make out a prescription of Atomoxetine for Patient B which he later presented at a Boots pharmacy. XXX.

39. Mr Rigby submitted that Dr Trivedi returned to the pharmacy on 18 January 2022. Then on 19 January 2022, Dr Trivedi met up with Dr A and did not inform him that XXX. Instead, he denied what he had done even when confronted with the email from Patient B. Mr Rigby submitted that the Tribunal may think that with a bit of reflection Dr Trivedi would have made it his business to see Dr A, XXX to tell them what had happened. Mr Rigby

submitted that Dr Trivedi did not do anything until he sent the text messages to Dr A on 21 January 2022 XXX. Dr Trivedi did not say anything about XXX, nor indeed that he had himself prescribed the medication for Patient B.

40. XXX

41. Mr Rigby submitted that there appeared to be four possibilities in relation to Dr Trivedi's state of mind:

1) XXX

2) XXX

3) That Dr Trivedi's actions were wholly voluntary, and his explanation is an opportunistic excuse based on his previous experience XXX.

4) If the Tribunal concludes that Dr Trivedi did XXX, his actions, certainly by his earliest account, were at least partially voluntary. Mr Rigby submitted that there were times in Dr Trivedi's evidence and reflection where he seemed to accept that XXX but thinking clearly and in an intellectual sense, for example, when he was thinking about prescribing the same medication he had previously thought was more suitable for Patient A.

42. Mr Rigby further submitted that if Dr Trivedi's conduct was voluntary or least significantly voluntary, his actions unquestionably amount to serious misconduct and breach GMP and Good Practice in Prescribing and Managing Medicines [2021]. He reminded the Tribunal that Dr C was clear there were several aspects of Dr Trivedi's treatment and care that were seriously below the standard expected.

43. Mr Rigby also submitted that the warning received by Dr Trivedi would be an aggravating factor if his conduct were wholly or partly voluntary as it demonstrates persistence in doing what he did.

44. Mr Rigby submitted that if the Tribunal determine that Dr Trivedi's actions were wholly or partially voluntary, then given the breaches of GMP and the Guidance on Prescribing, at the time of the misconduct, Dr Trivedi's fitness to practise was impaired. Mr Rigby submitted that even taking account of Dr Trivedi's insight and remediation, the Tribunal would need to consider whether Dr Trivedi has done enough to remediate what he has done. Mr Rigby submitted that if Dr Trivedi's actions were wholly voluntary, his fitness to practise remains impaired due to a lack of full insight and remediation. Mr Rigby stated however, that if Dr Trivedi's account of his actions is found to be true then his reflections would demonstrate a high level of insight and remediation.

45. XXX

Submissions on behalf of Dr Trivedi

46. XXX

47. XXX

48. XXX

49. Mr Cridland submitted that the Tribunal had to determine three issues. First, is Dr Trivedi guilty of misconduct. Second, if he is, is his fitness to practice currently impaired as a consequence. Third, XXX.

50. In relation to misconduct, Mr Cridland reminded the Tribunal of the relevant caselaw. He submitted that whether Dr Trivedi is guilty of serious professional misconduct is not a difficult philosophical, XXX or legal question. He submitted that in assessing the seriousness of Dr Trivedi's conduct, the Tribunal has to put it into the context in which it occurred. He postulated whether it was so serious or egregious that it warrants the censure of the disciplinary offence.

51. Mr Cridland submitted that there was no dispute that if Dr Trivedi knowingly and consciously took it upon himself to take the prescription script off the pad and go to Boots to obtain the medication for whatever reason, that would clearly amount to serious professional misconduct. However, he submitted that if Dr Trivedi was XXX, and as a consequence XXX, behaved in the way which has been admitted, and could not amount to serious professional misconduct.

52. Mr Cridland submitted that if the Tribunal accepts XXX and that this is why he behaved in the way that he did, then as night follows day, Dr Trivedi's behaviour does not amount to serious professional misconduct.

53. XXX

54. XXX

55. XXX

56. XXX

57. XXX

58. Mr Cridland invited the Tribunal to consider that if Dr Trivedi was not XXX but rather for his own benefit, then why would he leave his own telephone number and Patient B's telephone number with Boots pharmacy, particularly as the medication was not going to be ready and the pharmacist would inevitably call up Patient B to collect it. XXX

59. Mr Cridland invited the Tribunal to accept the evidence XXXX. Mr Cridland submitted that it would follow that Dr Trivedi's actions could not amount to serious professional misconduct.

60. XXX

61. Following his submissions, Mr Cridland was asked, given a submission made by Mr Rigby, whether the previous warning on Dr Trivedi's registration would be an aggravating factor if the Tribunal were to find that Dr Trivedi's actions were in any way voluntary. Mr Cridland submitted that the significance of a warning is for consideration at the sanction stage but that if the Tribunal accepts that Dr Trivedi's XXX, the previous warning would cease to carry any real weight.

The Relevant Legal Principles

62. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

63. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first, whether the facts as found proved amounted to misconduct and whether the said misconduct was serious. It must then consider whether, as a result of the misconduct, Dr Trivedi's fitness to practise is impaired today.

64. The LQC advised that misconduct is not defined with the Medical Act or the Rules, however in the case of *Roylance v GMC [2000] 1 AC 311* it was said that:

> *"'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. The misconduct is qualified in two respects. First it is qualified by the word professional which links the misconduct to the profession of medicine, Secondly the misconduct is qualified by the word serious. It is not any misconduct which would qualify. The professional misconduct must be serious."*

65. The Tribunal also took account of the case of *Nandi v GMC ([2004] EWHC (Admin))* where it was emphasised that the question of serious misconduct be given its proper weight, observing that in others it has been referred as '*conduct which would be regarded as deplorable by fellow practitioners.*' The LQC reminded the Tribunal that the use of deplorable should not be seen as a test, but rather a measure or indication to which conduct can be found to have fallen short of what is expected in the circumstances.

66. In the case of *Howden v Bar Standards Board [2017] EWHC 210 (Admin)* it was said that to amount to serious misconduct the conduct in question must be reprehensible, morally culpable

or disgraceful. Further, in the Judgment in *Solicitors Regulation Authority v Day [2018] EWHC 2726 (Admin)*, it was held that *'there is a set standard of seriousness or culpability for the purposes of assessing breaches of the core principles in tribunal proceedings. It is a question of fact and degree in each case. Whether the default in question is sufficiently serious and culpable thus will depend on the particular core principle in issue and on the evaluation of the circumstances of the particular case as applied to that principle…'*

67. In regard to the previous warning issued on Dr Trivedi's registration, the LQC advised that warnings should be viewed as a deterrent and have the effect of highlighting to the wider profession that certain conduct or behaviour is unacceptable. They are intended to remind the doctor that their conduct or behaviour previously fell significantly below the standard expected, and that repetition is likely to result in a finding of impairment of fitness to practise. Any breach of a warning may be taken into account by the Tribunal, and it may wish to consider the similarity in the nature of the conduct involved in the two cases, namely prescribing without authority to do so. The LQC however advised that circumstances in the previous case are different to the present case. The LQC further advised that whether the previous warning would carry any weight would depend on whether it concludes that Dr Trivedi acted wholly or partially voluntarily. If found to act voluntarily, the warning may be considered and demonstrate persistence. However, if found to be acting XXX, the previous warning may not be relevant. This is a matter for the tribunal to decide.

68. The Tribunal bore in mind that in determining whether the proven facts establish misconduct, it should consider whether Dr Trivedi breached any of the relevant provisions of *Good Medical Practice (2013 edition)* ('GMP') and *Good practice in prescribing and managing medicines and devices (2021 edition)* ('the Guidance on Prescribing'). The Tribunal must consider the extent of any breach and circumstances in which they occurred.

69. The LQC reminded the Tribunal the mere fact that a doctor may have breached the core principles of GMP does not in itself establish misconduct. Whether it does is a matter for the judgement of the Tribunal having had regard to the circumstances of the case.

70. The LQC advised that if the Tribunal finds allegation 1-3 to amount to serious misconduct, it must then go on to determine whether Dr Trivedi's fitness to practice is currently impaired by reason of that misconduct.

71. The Tribunal must have regard to the overarching objective which is to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

72. Whilst there was no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC and Paula Grant* [2011] EWHC 297 Admin. The Tribunal noted that any of the following features were likely to be present when a doctor's fitness to practise is found to be impaired:

a. 'Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b. Has in the past and/or is liable in the future to bring the medical profession into disrepute; and/or

c. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

73. The Tribunal must consider whether Dr Trivedi's fitness to practise is impaired at the present time. It must consider any evidence of insight, expressions of remorse and any further steps that have been taken towards remediation. As per the case of *Hawker v the Health and Care Professions Council [2022] EWHC 1228 (Admin),* the extent to which a Tribunal finds that the misconduct is capable of remediation depends on whether there is evidence that the doctor realises he has gone wrong and that he will not do anything similar in the future. The LQC reminded the Tribunal that admitting misconduct is not a prerequisite to establish that the doctor understands the gravity of misconduct and that it is unlikely to be repeated. However, a doctor's attitude to the underlying allegation should properly be taken into account when weighing up insight.

74. Further, in view of allegations 1-3, the Tribunal would need to consider whether or not, by virtue of XXX at the time, Dr Trivedi's actions amount to serious professional misconduct within the definition of caselaw.

75. XXX

76. XXX

77. XXX

The Tribunal's Determination on Impairment

Misconduct

78. In determining whether Dr Trivedi's fitness to practise is impaired by reason of misconduct, the Tribunal first considered whether the facts, admitted and found proved at paragraphs 1-3 of the Allegation, amounted to serious misconduct.

79. The Tribunal determined that the conduct itself breached various paragraphs of *Good Medical Practice (2013 edition).* It noted that Dr Trivedi had cited the new set 2024 GMP

which could not apply to conduct in 2022. It therefore considered the 2013 edition of GMP and found the following paragraphs to be engaged;

14 You must recognise and work within the limits of your competence.

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

…

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.

d consult colleagues where appropriate

e respect the patient's right to seek a second opinion

f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications

17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment…

19 Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

21 Clinical records should include:

a relevant clinical findings

b the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c the information given to patients

d any drugs prescribed or other investigation or treatment

e who is making the record and when.

31 You must listen to patients, take account of their views, and respond honestly to their questions.

37 You must be aware of how your behaviour may influence others within and outside the team.

47 You must treat patients as individuals and respect their dignity and privacy.

50 You must treat information about patients as confidential…

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

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

80. The Tribunal also considered the following paragraphs of the GMC guidelines in Good Practice in Prescribing and Managing Medicines (2021) to be engaged:

3 You are responsible for the prescriptions you sign. You are also accountable for your decisions and actions when supplying or administering medicines and devices, and when authorising or instructing others to do so.

13 You must be familiar with the guidance in the British National Formulary (BNF) and British National Formulary for Children (BNFC), which contain essential information to help you prescribe, monitor, supply, and administer medicines.

25 You must be satisfied that you have consent or other valid authority before examining or treating patients or involving patients or volunteers in teaching or research. More detail about this is given in our guidance on Decision making and consent which you must follow. If relevant to your practice, you must also follow our guidance on Making and using visual and audio recordings of patients.

40 You should reach agreement with the patient on the proposed treatment, explaining:

a. the likely benefits, risks and impact, including serious and common side effects.

b. what to do in the event of a side effect or recurrence of the condition.

c. how and when to take the medicine and how to adjust the dose if necessary.

d. how to use a medical device.

e. the likely duration of treatment

f. any relevant arrangements for monitoring, follow-up, and review, including further consultation, blood tests or other investigations, processes for adjusting the type or dose of medicine and for issuing repeat prescriptions.

50 You should be proportionate when obtaining a patient's consent. For most prescribing decisions, you can rely on a patient's verbal consent, as long as you are satisfied that they've had the opportunity to consider any relevant information and decided to go ahead. Sometimes a patient's signature is required on a form, for example to comply with an MHRA drug safety alert about a medicine with serious side effects.

93 Whether you prescribe with repeats or on a one-off basis, you must make sure that suitable arrangements are in place for monitoring, follow-up, and review. You should take account of the patients' needs and any risks arising from the medicines.

107 You must give patients, or their parents or carers, sufficient information about the medicines you propose to prescribe, to allow them to make an informed decision.

81. The Tribunal also had regard to the expert report provided by Dr C, dated 4 December 2023. In the report, Dr C identified a number of actions undertaken by Dr Trivedi in relation to the prescription written by him on 17 January 2022. He stated;

'My opinion is that, on 17.01.22, atomoxetine was not clinically indicated for Patient [B]. This is because he was already established on a satisfactory treatment that had been initiated by Dr A. Methylphenidate should be used with caution in patients with psychiatric comorbidity, but this risk had been assessed and Patient [B] was monitored by a specialist with appropriate experience (Dr A). Although Patient [B] reported some issues regarding his treatment with methylphenidate immediate release tablets (duration of action and probable side effects), he felt that the benefits outweighed the risks and wished to continue.'

82. Whilst he did not reference specific paragraphs of GMP 2013, he stated that the overall standard of care provided by Dr Trivedi to Patient B, on 17 January 2022, was seriously below the standards expected of a reasonably competent GP ST2 in a number of ways. He stated that Dr Trivedi's failings:

> *'…relate to fundamental aspects of medical practice, namely: working within your field of competence, working in partnership with patients, working collaboratively with colleagues and ensuring that documents are accurate and not misleading.'*

83. The Tribunal also had regard to the serious impact that Dr Trivedi's actions had on others. It noted that in addition to the extra work that Dr A had to undertake as a result of the incident, it also had the potential to impact Dr A's reputation. Dr A had also been professionally conflicted about the information he could release to Patient B about the investigation into Dr Trivedi's conduct. This also had a significant impact on Dr A. The Tribunal noted in the record of the investigatory interview meeting on 22 February 2022 that Dr A stated:

> '*This is such a unique and strange and painfully different is both patient and the trainee, it was so close. It could have been completely disastrous, so my focus was to keep my patient stable. I was really, really worried that week and it was a sleepless night. I have to admit.'*

84. In Patient B's evidence he stated that when he was messaged by Boots Pharmacy regarding the prescription he had assumed it was an unintentional error. He called the pharmacy and they queried whether he was taking Atomoxetine as this was on the prescription that was picked up. He described being shocked by this. He began to suffer a relapse in his mental health towards the end of January 2022, he had not been sleeping well and became agitated and suspicious. He described getting frustrated waiting for a call from Dr A. Due to the deterioration in his mental health, Patient B needed to take time off work.

85. The Tribunal also considered that staff at the Waterloo Centre and Boots Pharmacy were also affected by Dr Trivedi's actions. Having discovered that the medication was given to someone that was not the patient and of which the patient had no knowledge, this would have been a stressful and frightening experience for the pharmacy staff member involved.

86. The Tribunal noted Dr Trivedi's detailed reflections regarding the impact of his actions on others and that he had expressed genuine remorse for what had transpired, and it was clear that he had given this extensive thought.

87. However, despite his reflection and insight, the Tribunal concluded, were there no indication of XXX, Dr Trivedi's conduct would undoubtedly amount to serious misconduct. A finding of serious misconduct would be inevitable given the opinion of Dr C and given multiple breaches of GMP and GMC guidelines in Good Practice in Prescribing, as well as the serious impact the actions had on Patient B and others.

88. However, as Dr Trivedi had been XXX, the Tribunal therefore needed to consider whether there was sufficient evidence of XXX and whether this was sufficient to displace or mitigate any finding of serious professional misconduct.

Consultation on 16 December 2022

89. In regard to Dr Trivedi's telephone consultation with Patient B on 16 December 2021, the GMC suggested that Dr Trivedi overstepped his role in suggesting Atomoxetine to Patient B and he did the same thing again on 17 and 18 January 2022 but on that occasion prescribed that drug without any consultation with the patient. It was therefore necessary for the Tribunal to also look into Dr Trivedi's actions on 16 December 2021.

90. The Tribunal considered Dr C's report in which he gave the opinion that *'… the consultation record made by Dr Trivedi on 16.12.21 was of a high standard. This is because it was comprehensive, clearly structured and appropriately detailed.'*

91. Dr William's also stated that: *'my opinion is that on 16.12.21 Dr Trivedi carried out an adequate and appropriate telephone consultation.'* He further stated *'my opinion is that Dr Trivedi had a responsibility to check that the prescription he issued on 16.12.21 was appropriate and safe.'* The Tribunal determined this dispels the GMC suggestion that Dr Trivedi should have just issued the repeat prescription and done nothing else.

92. In relation to alternative medication suggested to Patient B by Dr Trivedi on 16 December 2021, Dr C stated *'My opinion is that it was not necessary for Dr Trivedi to offer alternative treatments because Patient B was satisfied with his existing treatment and was due to be reviewed again by Dr A in a month's time. However, as set out above, my opinion is that it was reasonable for Dr Trivedi to mention possible alternative treatments in general terms…'* He further stated that *'whilst it was not appropriate on 16.12.21 for Dr Trivedi to suggest alternative treatments for Patient B because this was a complex case and treatment decisions should be made by an appropriate specialist… However,…in my opinion… it was appropriate for Dr Trivedi to mention possible alternative treatments in general terms.'*

93. The Tribunal noted the GMC's suggestion that Dr Trivedi should have just offered the repeat prescription of Methylphenidate and the questions to Patient B and the suggestion of alternative medication was not necessary. However, in view of Dr C's report, the Tribunal considered that it was reasonable for him to do so, and in so doing, he did not overstep his role.

94. The Tribunal was also mindful that no allegation had been brought against Dr Trivedi regarding the standard of care provided during the telephone consultation with Patient B on 16 December 2021 and thus concluded that there was nothing improper about the consultation on 16 December 2021. The Tribunal considered Dr Trivedi to be acting professionally and to a high standard at the time of the telephone consultation.

95. The Tribunal noted that the GMC's position is that Dr Trivedi's rational thinking from 16 December 2021 was evident in his subsequent actions and therefore could not be due to XXX. The GMC connected his subsequent actions with his previous rational inclination to prescribe Patient B with Atomoxetine when he had the opportunity to do so. The Tribunal would therefore need to consider whether Dr Trivedi's preference to issue Atomoxetine on

16 December 2021 to Patient B indicated that he was thinking rationally on 17 and 18 January 2022 or whether he prescribed this XXX.

96. XXX

97. XXX

98. XXX

99. XXX

100. XXX

101. XXX

102. XXX

103. XXX

104. XXX

105. XXX

106. XXX

107. The Tribunal bore in mind Dr Trivedi's oral evidence in which he stated that he was familiar with Atomoxetine and had training in ADHD. He stated that Methylphenidate is a controlled drug, however Atomoxetine is not and is therefore less potent and milder on the brain. It was clear that Dr Trivedi had prior knowledge and understanding of both drugs and a preference to Atomoxetine. He stated that he went on to prescribe it XXX. He stated that the decision to use that particular medication was his however XXX.

108. The Tribunal considered XXX. The Tribunal thus determined that whilst Dr Trivedi XXX, he would still be able to use his previous specialist knowledge XXX. It did not consider use of this prior knowledge to mean that Dr Trivedi was XXX and acted in a voluntary way but rather, whilst XXX, could still rely on his knowledge of the drug, his recollection of his previous consultation with Patient B and perhaps also his views on the drug Patient B was currently taking.

109. Further, XXX. Dr Trivedi stated in his oral evidence that he accepted that he did go to the chemist but that he wanted to XXX. The Tribunal accepted this explanation.

110. Moreover, the Tribunal considered that if Dr Trivedi's actions were not caused XXX, there was no obvious motivation for him to do what he did. If Dr Trivedi was surreptitiously prescribing with the intention to self-medicate, then it would have been illogical for him to

have written his personal mobile phone number on the back of the prescription and to have provided Patient B's contact details for future communications. Dr Trivedi would have known that Patient B would be contacted and that he would have subsequently been identified as having prescribed the medication for Patient B. Accordingly, the Tribunal considered that the most plausible explanation, XXX.

111. In assessing Dr Trivedi's evidence overall, the Tribunal considered his evidence to be credible XXX. Further, it was of the view that, after already having been subject to a live warning, it was unlikely that Dr Trivedi would soon after, willingly behave in the same way.

112. XXX

113. The Tribunal concluded that Dr Trivedi's misconduct was XXX linked to XXX. Notwithstanding the conduct itself would ordinarily amount to serious misconduct, the Tribunal determined that the nature of XXX at the time, was sufficient to negate a finding of serious misconduct in relation to allegation 1-3.

114. The Tribunal therefore concluded that Dr Trivedi's conduct at the time, did not amount to serious professional misconduct.

115. Accordingly, there were no grounds to consider impairment in relation to allegations 1-3.

XXX

116. XXX

117. XXX

118. XXX

119. XXX

120. XXX

121. XXX

122. XXX

The Tribunal considered other matters in Private