PUBLIC RECORD

Dates: 09/01/2023 – 03/02/2023
07/02/2023 - 09/02/2023
10/08/2023 – 14/08/2023
08/01/2024 - 09/01/2024

Medical Practitioner's name:	Dr Gary TUDOR
GMC reference number:	2306588
Primary medical qualification:	MB ChB 1976 University of Manchester

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Erasure

Tribunal:

Legally Qualified Chair	Mr Richard Wood
Lay Tribunal Member:	Mrs Valerie Blessington
Medical Tribunal Member:	Dr Helen Crabtree

Tribunal Clerk:	Mr Matt O'Reilly (09/01/2023-03/02/2023) Mr Andrew Ormsby (07/02/2023-09/02/2023 & 10/08/2023-14/08/2023) Miss Hinna Safdar (08/01/2024-09/01/2024)

Attendance and Representation:

Medical Practitioner:	Present and not represented
GMC Representative:	Mr Boyd Morwood, Counsel Ms Amy Rollings, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held partly in public and partly 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 - 02/02/2023

Background

1. Dr Tudor qualified as a doctor in Manchester and has over 40 years of medical experience. He has worked both in the NHS and privately as a GP.

2. Several local clinicians in varying contexts expressed concerns about Dr Tudor, both to the GMC and the CQC, about the clinical care when he was working at Tudor Medical Matters ('TMM'), in Rossendale, Lancashire. TMM opened for business in or around April 2017 with Dr Tudor as the only permanent doctor at the practice. Dr Tudor also worked for Pall Mall Medical (PMM), a private GP practice in Manchester. He continued to practise from PMM whilst he was working at TMM.

3. The matters before this Tribunal fall under the following areas. In broad terms those areas and the allegations within those areas, can be summarised as follows.

<u>The diagnosis and prescribing for patients</u>

4. The diagnosis of hypothyroidism and treatment for that hypothyroidism with levothyroxine in 9 patients, Patients A, B, C, D, E, F G, H and I. It is alleged that Dr Tudor diagnosed Patients A to I with hypothyroidism when it was against guidance, in that it was unsupported by blood test results and therefore not clinically indicated. It is further alleged that Dr Tudor then treated those patients for hypothyroidism with levothyroxine, when that treatment was also not clinically indicated. It is also asserted that Dr Tudor failed to obtain informed consent before prescribing levothyroxine to patients, and about the potential of experiencing serious side-effects from that treatment. It is also alleged he failed to make a record of the aforesaid matters, contrary to guidance.

5. Moreover, it is asserted that Dr Tudor prescribed other drugs, including methotrexate and controlled drugs, when it was not clinically indicated. There were also concerns as to the clinical care he provided, and his treatment of close family members.

<u>TMMs registration with the CQC</u>

6. It is alleged that Dr Tudor was responsible for ensuring TMM was registered with the CQC to carry out regulated activities as defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and that TMM failed to obtain such registration. Further, that Dr Tudor inappropriately provided diagnostic and screening procedures, and treatment of disease and injury, which were regulated activities under the said regulations, when TMM did not have the necessary registration.

Interim Orders Tribunal ('IOT') breaches, IOT dishonesty and practising whilst suspended

7. Concerns in respect of Dr Tudor and TMM first came to the notice of the GMC following a referral in or about December 2018. The concerns were, in particular, that the practice was providing clinical care outside of the statutory regimen. There were four Interim Order Tribunal hearings held, on 12 July 2019, 18 November 2019, 6 January 2020 and 18 February 2020.

8. The IOT on 12 July 2018 imposed an order of conditional registration on Dr Tudor stating that he should not provide medical services from TMM until it had been registered with the CQC. It also set out that Dr Tudor could only prescribe opioids, benzodiazepines, hypnotics and thyroxine once he had communicated with the patient's NHS GP and obtained the relevant medical records from them. Further, that Dr Tudor must not prescribe hormone treatments for patients without face to face (in person) consultations with the patients. The 18 November 2019 IOT varied the conditions slightly.

9. On 6 January 2020, the IOT is said to have found that Dr Tudor had made out a prescription to a patient referred to as Patient O, contrary to the conditions set out by the previous IOTs. Dr Tudor provided extenuating circumstances, namely that the prescription was a "one off". Conditions were allowed to continue, again with slight amendment.

10. The 18 February 2020 IOT had before it evidence that Dr Tudor had continued to see patients and prescribe potentially harmful and dangerous controlled drugs, in breach of the terms of his conditions. The 18 February 2020 IOT determined to suspend Dr Tudor's registration to be reviewed within 3 months. It is alleged that between 30 July 2019 and 26 May 2020 Dr Tudor breached one or more of the IOT conditions, and that he did so knowingly and dishonestly. In particular, it is alleged that Dr Tudor instructed his legal representative to falsely state to the IOT on 6 January 2020, that the prescription Dr Tudor issued to Patient O on 26 November 2019, was 'a single prescription and indeed it is the only prescription he has issued in the circumstances'. It is submitted by the GMC that he knew he had issued many other prescriptions between 12 July 2019 and 6 January 2020.

11. It is also alleged that Dr Tudor provided clinical care to patients when he knew his GMC registration was suspended, and that his actions in this regard were dishonest.

The Outcome of Applications Made during the Facts Stage

12. At the outset of the hearing, Mr Boyd Morwood, Counsel, on behalf of the GMC, made an application pursuant to Rules 31 and 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that service had been properly effected, and to proceed with this hearing, respectively, in Dr Tudor's absence. The Tribunal granted the application. Its full written decision can be found at Annex A.

13. On day one of the hearing, Mr Morwood made an application for matters which related to XXX, in relation to the application regarding service and proceeding in absence, to be heard in private. The Tribunal granted the application.

14. On day one of the hearing, Mr Morwood also made an application to amend paragraphs 36ai and 47 of the Allegation due to typographical errors:

> 36: On:
>
> a. 12 July 2019 at an IOT hearing, your General Medical Council ('GMC') registration was made subject to the following conditions:
>
> i. 'you (must) should not provide medical services from [Tudor Medical Matters ('TMM')] until the clinic has had its registration confirmed by the Care Quality Commission ('CQC') ('Condition 1');
>
> 47. You inappropriately provided diagnostic and screening procedures ('DSP'), a regulated activity, for patients at TMM between 19 July 2017 and 10 ~~December~~ September 2019, when TMM did not have the necessary registration with the CQC to carry out DSP, in breach of the Regulations.

He submitted that these were corrective amendments, that they were not material changes to the charge and that there would be no injustice to Dr Tudor in making the amendments. The Tribunal considered that the proposed amendments were corrective rather than material to the Allegation and was satisfied that there would be little, if any, injustice to Dr Tudor in making them. The Tribunal noted that Dr Tudor was not present and that this meant that he could not respond to the proposed amendments. It was satisfied that this was the result of Dr Tudor having made an informed decision not to participate in the hearing, having had access to professional legal advice. The Tribunal therefore determined to grant to the application pursuant to Rule 17(6) of the Rules.

15. On day four of the hearing, during the evidence of Dr AC, GMC Expert, the Tribunal noted that several references within his expert and supplementary expert reports were illegible. The Tribunal requested that Dr AC provide copies of these documents so that they could be read. At the outset of day five of the hearing, Dr AC had provided several documents to the Tribunal. Dr AC confirmed that not all of the documents he had provided had been a part of his expert reports, that he had provided some additional ones to assist the Tribunal. When considering the admissibility of these documents, the Tribunal determined that it

would keep the issue under review and consider whether they were fair and relevant, if and when referred to, and that it would not consider those that had not been previously submitted as part of Dr AC's reports unless specifically directed.

16. On day eight of the hearing, at the end of Mr Morwood's Stage 1 submission, he made an application to amend paragraphs 11, 13, 17, 21a, 24aiii, 33bii and 35 of the Allegation due to typographical errors. On day 9 of the hearing the Tribunal granted the application. The full written decision can be found at Annex B.

The Allegation

17. The Allegation made against Dr Tudor is as follows:

That being registered under the Medical Act 1983 (as amended):

Hypothyroidism Patients

Patient A

1. On 2 August 2017 you consulted with Patient A and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient A's blood results indicating a normal thyroid function. To be determined

2. On one or more of the dates set out in Schedule 1 you failed to:

    a. prescribe appropriately in that you prescribed Levothyroxine for Patient A when it was not clinically indicated; To be determined

    b. obtain informed consent from Patient A in that you did not advise Patient A:

        i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

        ii. of the potential for Patient A to experience serious side effects; To be determined

    c. make a record of having undertaken the actions referred to at paragraph 2b.

3. On one or more of the dates set out in Schedule 2 you failed to:

    a. prescribe appropriately in that you prescribed Methotrexate for Patient A when:

        i. it was not appropriate for you to do so without input from an appropriately qualified specialist; To be determined

ii. Patient A had not been diagnosed with:

1. rheumatoid arthritis; To be determined

2. psoriatic arthritis; To be determined

iii. you prescribed a higher dose than advised in the British National Formulary ('BNF') guidance; To be determined

iv. you did not:

1. also prescribe folic acid to limit the side effects of Methotrexate; To be determined

2. arrange for Patient A to be monitored before initiation of Methotrexate; To be determined

3. put a plan in place for Patient A to be monitored on a weekly/fortnightly basis after initiation of Methotrexate; To be determined

4. advise Patient A's NHS General Practitioner ('GP') of the prescription; To be determined

b. obtain informed consent from Patient A in that you did not adequately counsel Patient A on the use of Methotrexate; To be determined

c. make a record of having undertaken the action referred to at paragraph 3b. To be determined

Patient B

4. On 12 December 2017 you consulted with Patient B and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient B's blood results not clearly indicating hypothyroidism; To be determined

b. prescribe appropriately in that you prescribed:

i. Levothyroxine 25mcg when this was not clinically indicated; To be determined

ii. a Cosmofer injection when Patient B did not have iron deficiency anaemia. To be determined

5. On 1 May 2018 you inappropriately prescribed for Patient B in that you increased Patient B's prescription of Levothyroxine to 100mcg daily when this was not clinically indicated. To be determined

Patient C

6. On 2 February 2018 you consulted with Patient C and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient C's blood results indicating a normal thyroid function.

7. On one or more of the dates set out in Schedule 3 you failed to:

a. prescribe appropriately in that you:

i. prescribed Levothyroxine for Patient C when it was not clinically indicated; To be determined

ii. inappropriately increased the dose of Levothyroxine without undertaking further blood tests to see if Patient C's thyroid function had improved; To be determined

b. obtain informed consent from Patient C in that you did not advise Patient C:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential for Patient C to experience serious side-effects; To be determined

c. make a record of having undertaken the actions referred to at paragraph 7b. To be determined

8. On one or more of the dates set out in Schedule 4 you inappropriately prescribed diazepam for Patient C in that you prescribed it:

a. outside of:

i. BNF guidance; To be determined

ii. NICE guidance on the management of controlled drugs; To be determined

b. without recording your rationale for doing so.

9. Between 2 February 2018 and 19 May 2020 you failed to communicate your prescribing of medication for Patient C to her NHS GP. To be determined

Patient D

10. On or around 13 April 2018 you consulted with Patient D and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient D's blood results indicating a normal thyroid function; To be determined

b. prescribe appropriately for Patient D in that you prescribed Levothyroxine 25mcg once daily when it was not clinically indicated; To be determined

c. obtain informed consent from Patient D in that you did not advise Patient D:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential for Patient D to experience serious side-effects; To be determined

d. make a record of having undertaken the actions referred to at paragraph 10c. To be determined

Patient E

11. On 14 April 2018 you consulted with Patient E and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism ~~despite Patient E's blood results indicating a normal thyroid function~~ either:

a despite Patient E's blood results indicating a normal thyroid function or; To be determined

b without blood results To be determined

12. On one or more of the dates set out in Schedule 5 you failed to:

a. prescribe appropriately in that you:

i. prescribed Levothyroxine for Patient E when it was not clinically indicated; To be determined

ii. inappropriately increased the dose of Levothyroxine:

1. without undertaking further blood tests to see if her thyroid function had improved; To be determined

2. despite recent blood results indicating a normal thyroid function; To be determined

b. obtain informed consent from Patient E in that you did not advise Patient E:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential for Patient E to experience serious side-effects; To be determined

c. make a record of having undertaken the actions refer to at paragraph 12b. To be determined

13. You prescribed and/or administered a Cosmofer injection for Patient E when this was not clinically indicated on:

a. ~~16~~ 13 June 2018; To be determined

b. 17 October 2018; To be determined

c. 21 March 2019. To be determined

14. Between 14 April 2018 and 11 June 2019 you failed to communicate your prescribing of opiates for Patient E to her NHS GP. To be determined

Patient F

15. On 14 February 2019 you consulted with Patient F and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient F's blood results indicating a normal thyroid function; To be determined

b. prescribe appropriately for Patient F in that you prescribed Levothyroxine 50mcg daily when it was not clinically indicated; To be determined

c. obtain informed consent from Patient F in that you did not advise Patient F:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential for Patient F to experience serious side-effects; To be determined

d. make a record of having undertaken the actions referred to at paragraph 15c. To be determined

16. On 12 June 2019 you consulted with Patient F and you failed to prescribe appropriately in that you increased the dose of Levothyroxine for Patient F:

a. when it was not clinically indicated; To be determined

b. without undertaking further blood tests to see if her thyroid function had improved. To be determined

Patient G

17. On 22 February 2019 you consulted with Patient G and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient G's blood results indicating a normal ~~forward~~ thyroid function. To be determined

18. On one or more of the dates set out in Schedule 6 you failed to:

a. prescribe appropriately for Patient G in that you:

i. prescribed Levothyroxine when it was not clinically indicated; To be determined

ii. increased the dose of Levothyroxine for Patient G:

1. without undertaking further blood tests to see if her thyroid function had improved; To be determined

2. despite recent blood results indicating a normal thyroid function; To be determined

b. obtain informed consent from Patient G in that you did not advise Patient G:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential for Patient G to experience serious side-effects; To be determined

c. to make a record of having undertaken the actions referred to at paragraph 18b. To be determined

19. Your actions as described at paragraph 18 caused Patient G to become hyperthyroid as indicated by blood test results taken on:

a. 15 January 2019; To be determined

b. 6 December 2019. To be determined

20. You prescribed and/or administered a Cosmofer injection for Patient G when it was not clinically indicated on:

a. 14 July 2018; To be determined

b. 15 August 2018; To be determined

c. 1 March 2019. To be determined

Patient H

21. On 22 February 2019 you consulted with Patient H and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism without any blood results ~~despite Patient H's blood results indicating a normal thyroid function;~~ To be determined

b. prescribe appropriately in that you prescribed Levothyroxine 50mcg daily when it was not clinically indicated; To be determined

c. obtain informed consent from Patient H in that you did not advise Patient H:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential to experience serious side-effects; To be determined

d. make a record of having undertaken the actions referred to at paragraph 21c. To be determined

22. On 13 March 2019 you inappropriately prescribed for Patient H in that you increased the dose of Levothyroxine for Patient H:

a. when it was not clinically indicated; To be determined

b. without undertaking further blood tests to see if her thyroid function had improved. To be determined

Patient I

23. On or around 12 September 2019 you consulted with Patient I and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient I's blood results indicating a normal thyroid function; To be determined

b. prescribe appropriately in that you prescribed Levothyroxine 50mcg once daily when it was not clinically indicated; To be determined

c. obtain informed consent from Patient I in that you did not advise Patient I:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; To be determined

ii. of the potential for Patient I to experience serious side-effects; To be determined

d. make a record of having undertaken the actions referred to at paragraph 23c. To be determined

24. On one or more of the dates set out in Schedule 7 you failed to:

a. prescribe appropriately for Patient I in that you prescribed Methotrexate:

i. when it was not appropriate for you to do so without input from an appropriately qualified specialist; To be determined

ii. when Patient I had not been diagnosed with:

1. rheumatoid arthritis; To be determined

2. psoriatic arthritis; To be determined

iii. at a higher dose ~~bond~~ band than is advised in the BNF guidance: To be determined

iv. without:

1. also prescribing folic acid to limit the side effects of Methotrexate; To be determined

2. arranging for Patient I to be monitored before initiation of Methotrexate; To be determined

3. putting a plan in place for Patient I to be monitored on a weekly/fortnightly basis after initiation of Methotrexate; To be determined

4. advising Patient I's NHS GP of the prescription; To be determined

b. obtain informed consent from Patient I for the prescription of Methotrexate in that you did not advise Patient I:

i. of the possibility of serious adverse effects; To be determined

ii. that overdose can be fatal; To be determined

iii. that regular blood testing is essential; To be determined

iv. that she should not conceive because Methotrexate is teratogenic; To be determined

c. make a record of having undertaken the actions referred to at paragraph 24b. To be determined

Treatment of family members

Patient J

25. On one or more of the dates set out in Schedule 8 you inappropriately provided the treatment and/or care set out in Schedule 8 to Patient J with whom you had a close personal relationship, in that there was no necessary reason for you to treat Patient J on those occasions. To be determined

26. You prescribed for Patient J in relation to anxiety and/or depression but failed to undertake a suicide risk assessment on:

    a. 8 December 2017; To be determined

    b. 3 January 2018. To be determined

27. You failed to advise Patient J's NHS GP of the treatment you had provided as described at paragraphs 25-26. To be determined

Patient K

28. On one or more of the dates set out in Schedule 9 you inappropriately provided the treatment and/or care set out in Schedule 9 to Patient K with whom you had a close personal relationship, in that there was no necessary reason for you to treat Patient K on those occasion. To be determined

29. Between 3 November 2017 and 22 November 2018 you failed to advise Patient K's NHS GP of the treatment you had provided as described at paragraph 28. To be determined

30. On 3 November 2017 you consulted with Patient K and failed to:

    a. take any history from Patient K's parent; To be determined

    b. carry out an adequate examination in that you did not undertake:

        i. a general examination to determine:

            1. Patient K's overall appearance; To be determined

            2. whether Patient K was alert; To be determined

            3. whether Patient K was distressed; To be determined

        ii. any basic physiological observations; To be determined

        iii. an examination of Patient K's chest; To be determined

c. obtain informed consent from Patient K's parent in that you did not provide Patient K's parent with:

i. advice on the possible side effects of the medication you prescribed; To be determined

ii. safety netting advice; To be determined

d. prescribe appropriately in that you prescribed the following medication when it was not clinically indicated:

i. Phenergan; To be determined

ii. Erythromycin; To be determined

e. make a record of having undertaken the actions referred to at paragraph 30a-c. To be determined

31. On 16 October 2018 you consulted with Patient K and failed to:

a. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. Patient K's overall appearance;
To be determined

2. whether Patient K was alert; To be determined

3. whether Patient K was distressed;
To be determined

ii. any basic physiological observations; To be determined

b. obtain informed consent from Patient K's parent in that you did not provide Patient K's parent with:

i. advice on the possible side effects of the medication you prescribed; To be determined

ii. safety netting advice; To be determined

c. prescribe appropriately in that you prescribed Co-amoxiclav when it was not clinically indicated; To be determined

d. make a record of having undertaken the actions referred to at paragraph 31a-b. To be determined

32. On 21 November 2018 you consulted with Patient K and failed to:

a. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. Patient K's overall appearance;
To be determined

2. whether Patient K was alert; To be determined

3. whether Patient K was distressed;
To be determined

ii. any basic physiological observations; To be determined

b. obtain informed consent from Patient K's parent and that you did not provide Patient K's parent with:

i. advice on the possible side effects of the medication prescribed; To be determined

ii. safety netting advice; To be determined

c. make a record of having undertaken the actions referred to at paragraph 32a-b. To be determined

General clinical concerns

Patient L

33. On 8 March 2018 you consulted with Patient L and you failed to:

a. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. her overall appearance: To be determined

2. whether she was alert: To be determined

3. whether she was distressed; To be determined

ii. basic physiological observations of Patient L's:

1. heart rate; To be determined

2. respiratory rate; To be determined

3. capillary refill time; To be determined

4. oxygen saturation; To be determined

b. prescribe appropriately in that you prescribed:

i. Co-amoxiclav when it was not clinically indicated; To be determined

ii. a ~~Beclemtasome~~ Beclometasone inhaler when ~~Beclemtasome~~ Beclometasone was an unlicensed treatment for someone of Patient L's age; To be determined

c. obtain informed consent from Patient L's parents:

i. for the prescription of Co-amoxiclav in that you did not provide Patient L's parents with:

1. advice on the potential side effects of the medication; To be determined

2. safety netting advice; To be determined

ii. for the prescription of a ~~Beclemtasome~~ Beclometasone inhaler in that you did not inform Patient L's parents that the prescription was:

1. outside of the licenced indication of the medication; To be determined

2. inconsistent with relevant guidance; To be determined

d. make a record of having undertaken the actions referred to at paragraph:

i. 33a; To be determined
ii. 33c. To be determined

Patient M

34. On 29 May 2018 you consulted with Patient M and inappropriately prescribed one or more of the medications set out in Schedule 10 in that you:

    a. prescribed the medication when it was not clinically indicated; To be determined

    b. failed to obtain any confirmatory evidence for Patient M's ongoing prescription; To be determined

    c. failed to obtain any details of the psychiatric care Patient M may have been receiving; To be determined

    d. prescribed the medication in excessive quantities. To be determined

Patient N

35. On 14 May 2020 you consulted with Patient N and you failed to:

    a. prescribe appropriately in that you prescribed Clopidogrel 75mg daily for anti-phospholipid syndrome:

        i. when her condition had not been considered by an appropriately qualified specialist; To be determined

        ii. in addition to an ongoing prescription of aspirin 300mg daily; To be determined

    b. obtain informed consent from Patient N in that you did not advise Patient N that:

        i. the decision to prescribe Clopidogrel was contrary to relevant guidance; To be determined

        ii. of the potential for Patient N to experience serious side-effects; To be determined

    c. make a record of having undertaken the actions refer to at paragraph 35b. To be determined

Interim Orders Tribunal ('IOT') breaches, IOT dishonesty and practising whilst suspended

36: On:

a. 12 July 2019 at an IOT hearing, your General Medical Council ('GMC') registration was made subject to the following conditions:

i. 'you ~~must~~ should not provide medical services from [Tudor Medical Matters ('TMM')] until the clinic has had its registration confirmed by the Care Quality Commission ('CQC') ('Condition 1'); To be determined

ii. 'you must only prescribe opioids, benzodiazepines, hypnotics once you have communicated with the Patient's NHS GP and obtained the relevant medical records from them ('Condition 2'); To be determined

iii. 'you must not prescribe hormone treatments without face to face (in person) consultations with the Patients ('Condition 3'); To be determined

b. 18 November 2019, the IOT amended Condition 1 to 'you must not provide medical services from [TMM] until the clinic has had its registration confirmed by the CQC for those services' ('Condition 4');To be determined

c. 6 January 2020, the IOT amended:

i. Condition 3 to 'you must not prescribe thyroxine unless you have communicated with the Patient's NHS GP and obtained the relevant medical records from them' ('Condition 5'); To be determined

ii. Condition 4 to 'you must not provide medical services from [TMM] clinic including diagnostic and screening procedures or the treatment of disease, disorder or injury unless the clinic has had its registration for these activities confirmed by the CQC' ('condition 6'). To be determined

37. Between 30 July 2019 and 26 May 2020 you breached one or more of the IOT conditions referred to in paragraph 36 as set out in Schedule 11. To be determined

38. When you carried out the actions referred to at paragraph 37 and Schedule 11 you knew your GMC registration was subject to the IOT conditions referred to at paragraph 36. To be determined

39. Your actions as described at paragraph 37 and Schedule 11 were dishonest by reason of paragraph 38. To be determined

40. You instructed your legal representative to falsely state, at an IOT review hearing on 6 January 2020, that the prescription you issued to Patient O on 26 November 2019, referred to in Schedule 11, was 'a single prescription and indeed it is the only prescription he has issued in the circumstances'. To be determined

41. When you instructed your legal representative to make the statement set out at paragraph 40 you knew you had also issued one or more other prescriptions between 12 July 2019 and 6 January 2020, as set out in Schedule 11. To be determined

42. Your actions described at paragraph 40 were dishonest by reason of paragraph 41. To be determined

43. You:

    a. had your registration with the GMC suspended by the IOT between 18 February 2020 and 5 May 2020; To be determined

    b. provided clinical care to patients between 2 March 2020 and 5 May 2020 as set out in Schedule 12. To be determined

44. When you provided the clinical care described in paragraph 43b and Schedule 12 you knew:

    a. your GMC registration was suspended as described in paragraph 43a; To be determined

    b. that the suspension of your GMC registration meant that you should not provide clinical care. To be determined

45. Your actions described at paragraph 43b where dishonest by reason of paragraph 44. To be determined

Care Quality Commission ('CQC') Conviction for TMM

46. You were responsible for ensuring that TMM was registered with the CQC to carry out regulated activities as defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulations'). To be determined

47. You inappropriately provided diagnostic and screening procedures ('DSP'), a regulated activity, for patients at TMM between 19 July 2017 and 10 ~~December~~ September 2019, when TMM did not have the necessary registration with the CQC to carry out DSP, in breach of the Regulations. To be determined

48. You inappropriately provided treatment of disease and injury ('TDDI'), a regulated activity, to patients at TMM between 19 July 2017 and 14 February 2020 when TMM did not have the necessary registration with the CQC to carry out TDDI, in breach of the Regulations. To be determined

Witness Evidence

18. The Tribunal received a GMC expert report from Dr AC, dated 26 April 2021. It also received supplemental expert reports, dated 16 August 2021 and 16 June 2022. Dr AC also provided oral evidence at the hearing.

19. The Tribunal received witness statements from the following witnesses who were not called to give oral evidence:

- Ms R, Registration Inspector for the Care Quality Commission (CQC), dated 30 June 2020;
- Mr S, Professional Adviser for the NHS England Area Team, Greater Manchester, Lancashire and South Cumbria, dated 24 July 2020;
- Mr T, a GMC Investigation Officer in the Regional Investigation Team of the Fitness to Practise Directorate, dated 7 April 2020.

Documentary Evidence

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

- Ms R's CQC witness statement, dated 20 January 2020;
- Screenshots of Tudor Medical Matters and Companies House Websites, undated;
- Unregistered Provider Letter sent to Tudor Medical from the CQC, dated 12 September 2018;
- CQC documented discussion with Mr S, dated 13 September 2018;
- CQC documented discussion with Dr Tudor, dated 13 September 2018;
- Appointments list, various dates;
- Contract of employment for Dr Tudor, dated 25 September 2018;
- Extracts from TMMs Day Book, various dates;

- Employers Liability Insurance certificate, dated 3 October 2018;
- GP services price list, undated;
- Medical supplies invoice, dated 13 September 2018;
- Concerns raised by CCG, dated 30 November 2018;
- Email from Mr S, dated 4 December 2018;
- PACE letter and pre interview disclosure, dated 31 December 2018;
- Screenshot of Tudor Medical Matters Facebook, undated;
- Screenshot of Tudor Medical Matters website, dated June 2019;
- Transcript of PACE interview, dated 8 April 2019;
- Notice of Proposal to refuse registration, dated 22 October 2020;
- Screenshot from the CQC computer system showing the dates Tudor Medical Matters was granted registration, dated 17 October 2019 and 24 February 2020;
- Tudor Medical Matters Certificate of CQC registration, dated 13 November 2019;
- Updated Tudor Medical Matters Certificate of CQC registration, dated 27 February 2020;
- CQC Certificates of registration for Dr Tudor, dated 13 November 2019 and 27 February 2020;
- Mr S's CQC witness statement, dated 1 July 2019;
- Report from Superdrug Pharmacy raising concerns regarding Dr Tudor's prescribing of oxazepam, dated 12 June 2018;
- Prescriptions issued by Dr Tudor, various dates;
- Various emails from Mr S to the CQC;
- IOT determinations, dated 12 July 2019, 18 November 2019 and 18 February 2020;
- Letter to Dr Tudor from the MPTS, dated 15 July 2019, 19 November 2019 and 7 January 2020;
- Referral from Mr U, Pharmacist, to the GMC, dated 29 November 2019 and a prescription received from Mr U, dated 27 November 2019;
- Emails between the GMC & the CQC, dated 5 December 2019;
- Referral from Dr V, Fairmore Practice, Rawtenstall to the GMC, dated 13 December 2019;
- IOT determination and transcript, dated 6 January 2020;
- Referral from Waterfoot Medical Practice, dated 13 January 2020, and various emails to the GMC;
- Emails between GMC and the CQC, dated 5 February 2020;
- Initial complaint to the GMC and further information from Mr W, dated 4 December 2018 and 18 December 2018;

- Various email correspondence from Pall Mall Medical to the CQC and GMC;
- Email from Mr X, Duty Pharmacy Manager, Tesco Pharmacy, enclosing private prescriptions 22/05/2020;
- Online complaint form from Mr Y, Clinical Pharmacist, Glenroyd Medical, dated 4 June 2020, and various email correspondence to NHS Blackpool CCG;
- Email from Mr S enclosing: - Emails from Irwell Medical Practice 19 June 2020 and email from Asda Pharmacy 30 June 2020, and 3 June 2020;
- Letter from Mr X enclosing bundle of prescriptions 30 June 2020
- Email from Mr AA at Asda Pharmacy enclosing: prescription, dated 17 July 2020 and Emergency Alert Notification, undated;
- Email from Ms Z, Clinical Pharmacist, Irwell Medical Practice to NHS England, dated 29 July 2020;
- Memorandum of Conviction, dated 18 November 2020.
- Medical records for Patient A, B, C, D, E, F, G, H, I, J, K, L, M, N, P and Q, various;
- National Health Service, England, Social Care, England, Public Health, England - The Health and Social Care Act 2008(Regulated Activities) Regulations 2014;
- Dr Tudor's Rule 4 response, dated 17 January 2018;
- Dr Tudor's Rule 7 response, dated 7 December 2021;
- Guidance from NICE: Neck pain - acute torticollis, dated April 2015;
- Guidance from 'emc- Cosmofer - Pharmacosmos UK Limited: Summary of Product Characteristics (SmPC), dated 28 January 2020;
- NICE article: Scenario: Viral-induced wheeze/infective exacerbation of asthma, dated February 2017;
- NICE guidance on Asthma, dated 2018.

The Tribunal's Approach

21. In reaching its decision on the facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Tudor does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, that is to say the Tribunal must determine whether it is more likely than not that the alleged events occurred.

22. The Tribunal also bore in mind that it should assess and determine each paragraph and sub-paragraph of the Allegation separately. It noted that while it can draw safe inferences from the evidence, it must not speculate. The Tribunal took account of the requirement to examine all the evidence carefully and fully and to give sufficient and clear reasons so that the parties are able to understand how it has reached its decision.

The Tribunal's Analysis of the Evidence and Findings

23. The Tribunal took into account the submissions of Mr Morwood. It evaluated all the evidence it had received, oral and documentary, in making its findings on the facts. The Tribunal decided that it would address firstly those matters in respect of the CQC, secondly those in respect of alleged breaches regarding the IOT hearings, and thirdly, the specific allegations in respect of the individual patients.

24. The Tribunal noted that Dr Tudor had been practicing for more than 40 years. It remained cognisant throughout its deliberations that there have been no previous findings in GMC fitness to practise proceedings and no warnings given in respect of Dr Tudor. It approached all decision making in this case on the basis of Dr Tudor being of good character. Firstly, this was relevant to the question of whether Dr Tudor was likely to have committed the Allegation. Secondly, it was relevant as to whether Dr Tudor was telling the truth, in so far as the Tribunal had access to evidence from Dr Tudor.

Care Quality Commission ('CQC') Conviction for TMM

25. Tudor Medical Matters Limited (TMM), was a limited company, based in Rossendale, Lancashire. It was a business from which regulated medical services were provided, i.e. a private GP surgery. XXX was the sole director of the company at the relevant times. Dr Tudor was not an officer of the company, although he was the only GP, or person with medical qualifications, working at the practice. He was therefore the person who managed all medical matters arising out of the running of the business. TMM began accepting patients in or around April 2017.

26. Dr Tudor provided services for another private practice called Pall Mall Medical. The earliest medical records the Tribunal had before it were from July 2017 for Patient A. The Tribunal noted that Dr Tudor continued to practise at Pall Mall Medical whilst he was working at TMM.

27. The Tribunal noted that the lay evidence of Ms R and that of the CQC's concerns expressed throughout her witness statements was not contested either pre-hearing or during the hearing by way of cross examination. As a consequence, the Tribunal accepted her testimony.

28. In her witness statement, Ms R stated that the 'Health and Social Care Act 2008 (Regulated activities) Regulations 2014' set out that any service provider who wishes to carry out regulated activities must be registered with the CQC. She stated those regulations also set out a full list of the regulated activities. These included 'Diagnostic and screening procedures' (DSP) which includes taking blood samples sent for external analysis, and 'Treatment of disease, disorder or injury' (TDDI), which includes the prescribing of medication.

29. Ms R stated that a service provider must be registered separately with the CQC for each of the regulated activities provided. If the service provider is an organisation or partnership, they also need to have a registered manager for each regulated activity (referred to in the regulations as a 'nominated individual'). She stated that the nominated individual is responsible for the day-to-day delivery of the regulated activity at the organisation.

30. Ms R further explained that it is a criminal offence for an organisation to carry on a regulated activity without being registered with the CQC under section 10 of the Health and Social Care Act 2008 (HSCA 2008). She observed that TMM was not registered with the CQC for any regulated activities at all in 2017 or 2018.

31. On 4 September 2018 the CQC received information that Tudor Medical Matters was operating as an unregistered provider. The Tribunal had before it evidence of the initial referral to the CQC of 4 September 2018 and of the investigation which followed.

32. The CQC sent an unregistered provider letter (URP letter) to Tudor Medical Matters, dated 12 September 2018. This letter explained that the CQC had concerns that TMM were carrying on regulated activities (DSP and TDDI) without being registered to do so. It also set out that TMM were therefore potentially committing a criminal offence under the HSCA 2008. Separate letters, both dated 12 September 2018, were sent in respect of each the regulated activities and TMM could respond confirming they:

i. were not carrying on regulated activities and the reasons why they believe they were not;
ii. would cease carrying on regulated activities; or
iii. would apply for registration and agree to cease carrying on regulated activities until registration was granted.

33. In her witness statement to the CQC in relation to her investigation of TMM, dated 20 January 2020, Ms R stated:

> *"10. On 13 September 2018, Dr Tudor called the CQC National Customer Service Centre to discuss the letters he had received and requested a call from the inspector. I called Dr Tudor on 13 September 2018. Dr Tudor confirmed that they were carrying on these regulated activities and asked if he could explain. Dr Tudor informed me that they opened 20 months ago with every intention of registering with the commission. He stated that they carried on providing the service and the application to register was not submitted as they never got around to it. Dr Tudor confirmed that he will apply to be registered and will respond to the letter received with the appropriate option (option 1).*
>
> **…**
>
> *12. On 14 September 2018, the CQC received a response to the URP letters from Dr Tudor stating that they would apply to register.*

Unregistered Provider Visit

13. An unregistered provider (URP) visit to Tudor Medical Matters Ltd took place on 24 October 2018, with; myself, Ms AF (Registration Inspector) and Mr AG (pharmacy specialist). Dr Tudor and XXX, Mrs AH who is a director of the company was present during the visit. The purpose of the URP visit was to explain to the provider that the CQC have reasons to believe that they are carrying on regulated activities without registration and we were present to inspect the premises and gather evidence to this effect.

…

15. Dr Tudor explained at the start of the visit that he had applied for his DBS to start the application process for registration. During the visit, Dr Tudor chased this, and it was noted that the application had not been submitted correctly. Dr Tudor stated that he would rectify this as soon as possible.

16. An application to register was received by the CQC on 20 December 2018 and assigned to Registration Inspector Ms AI. This application was subsequently withdrawn by the provider on 1 April 2019. On 18 April 2019 Tudor Medical Matters Ltd applied for registration with the CQC for the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury. On 13 November 2019 registration was granted for diagnostic and screening procedures but refused for treatment of disease, disorder or injury. Dr. Tudor is currently appealing this decision.

34. Dr Tudor took part in a Police and Criminal Evidence Act 1984 (PACE) interview on 8 April 2019. The purpose of the interview was to establish whether the section 10 offence of carrying on regulated activities without registration with the CQC had been committed. Dr Tudor decided not to have representation with him at the interview and attended alone. He accepted during the PACE interview that when TMM was visited on the 24 October 2018 the waiting room was full. He further admitted that Tudor Medical Matters had been carrying on regulated activities (DSI and TDDI), without CQC registration. In his PACE interview it was also recorded that:

"Tudor I am a general practitioner. I work for Tudor Medical Matters; I'm not a director of Tudor Medical Matters.

Mx AJ Do you, are you a person who's got a significant control?

Tudor I advise the, XXX who is, is the director…

…

Tudor …I initially worked for Pall Mall in Manchester…

…

Tudor *…but as the company got busier I did less for Pall Mall and more for Tudor Medical…*

Mx AJ *And were you the only one dealing with prescriptions?*

Tudor *Yes.*

…

Tudor *And having had experience of trying to get a, a DBS certificate before, I did the things, applied for it, and I just sat and waited for the number. Somewhat naively looking back I have to say a number didn't come. And it didn't come into junk box or email or anything. I couldn't find it. And then the next thing was we had a visitation, which is not, you know, it was unexpected, but not surprising con-considering the circumstances.*

In respect of screenshots of the TMM website:

Mx AL *It says: "Don't forget that we will be reopening after our redecoration on Monday the 11th of March at 9:30 a.m. and clinics begin again on Tuesday. Thankyou so much for your patience during this period-*

Tudor *Yes.*

Mx AL *-if you have left us a repeat prescription request whilst we have been closed please allow two working days for them to be processed."*

Tudor *Yes, that's absolutely true, yeah.*

The Tribunal noted that Dr Tudor accepted that he was still undertaking regulated clinical activities, namely prescribing, when he was not registered to do so. He further stated:

Tudor *-because I, I came back and the waiting room was full and XXX was just sat behind the desk looking as though someone had shot her, uh, and said it's the CQC, I said oh good, good, w-we've, come for an inspection. And, and Ms R, I think somebody said no-*

Mx AJ *No.*

Tudor *-not an inspection, uh. And yeah it, uh, it was a bit of a blur after that…*

…

Mx AJ *Uh, I'm going to ask you to give me a wild guess. Do you know how many you've got on your books?*

Tudor *Uh, about 1,200 now.*

…

Mx AJ *Ok. Can you confirm that the company Tudor Medical Matters has been continuously providing regulated activity, dognistics-diagnostic and screening procedures and treatment of disease, disorder and injury from 3a Bank Street, namely carrying gout blood tests –*

…smear tests…

…-and diagnosing disease, disorder, or prescription of medicines for the purpose of treating disorder or injury from, we've said 28th of October 20147, but it was, you reckon it was April time-ish, was it?

Tudor *Well, it, it was opened, the doors wee opened in April and yes of course then, uh, if the doors are open then we're in a position to carry out those procedures, but, uh, not many people came in at first, but towards the end of '17 it's, business picked up…*

…

Mx AJ *So you're still providing that regulated activity.*

Tudor *Yes and we did apply for registration again immediately.*

Mx AJ *But you're, you're not registered as yet?*

Tudor *Not of yet.*

… Yeah, I accept what you say, I accept, uh, that we seem to have breached the regulations, I accept that, but it was, it's not deliberate. It wasn't deliberate from the outset. It was, uh, it was a genuine mistake. Because firstly, uh, I misinterpreted the rules. I looked at the rules and, um, there's one part of it that, that, that suggests that if you're a registered med-medical practitioner, um, and you work for a CQC regulated company on one hand and also you belong to a designated body on the other hand, you're exempt. Now, I don't know, I read those two things and that's why I didn't go for registration straight or we didn't go for registration straightaway. I misinterpreted the rules with, with, in retrospect.

…

Mx AJ *-applying doesn't make you regulated, does it? You're, you're an intelligent man, you're not going to say to me…*

Tudor *No, but honestly, I, I, on the basis of applying we, we've assumed we could carry on.*

…

Mx AJ *We've written to you, we've clearly said you're in breach. And then you, you've gone to start the ball rolling with for getting what you need to and I'd like to think you've gone on and exactly know what you've got to do, but you've continued this activity for the next six, seven months.*

Tudor *Hmm.*

Mx AJ *Is that fair?*

Tudor *Yeah, it is fair.*

Mx AJ *Uh, and, and you're still not registered. You have applied. I understand, uh, but you're still not registered and you are aware you should be registered. Is that fair?*

Tudor *Yeah, it is fair.*

…

Tudor *-and we assumed that that was carte blanche to carry on.*

…

Mx AJ *When did you apply to the CQC?*

Tudor *As soon as Ms R's team came.*

Mx AJ *You, you actually put in an application form?*

Tudor *Yes. Yeah. Yeah. Yeah.*

Mx AJ *And that's been ongoing since, but you've continued.*

Tudor *Yeah, we assumed that was ok, because we applied.*

Mx AJ *Ok.*

Tudor *And it would, would have been backdated anyway to the application presumably.*

Mx AJ *I'm not sure about that.*

…

Mx AL *Applying for registration isn't registration though, is it?*

Tudor *No. No.*

Mx AL *-because the application could potentially be refused?*

Tudor *But I didn't, I didn't realise that at the time. I didn't know that at the time. I assumed that-*

Mx AL *Because it's not guaranteed, it it, that-*

Tudor *-we could carry on.*

Mx AL *- you get registration, is it?*

Tudor *Nothing's guaranteed I suppose.*

…

Tudor *No. I shall say again it was an honest mistake to begin with. Um, I accept that y-yeah, I mean I hadn't realised we had to stop trading. I thought we could carry on, uh, whilst the, y-you know, the application was in progress. Um, uh, and, and that's come as a shock to me today, because that wasn't my intention."*

35. Dr Tudor's position appeared to be that as he was awaiting his DBS Certificate; and as he had submitted an application for registration to the CQC; and as he was working in another private practice which was CQC regulated, that Dr Tudor and TMM were compliant with requirements for registration. The Tribunal did not accept these representations. Dr Tudor's representations clearly did not set out the regimen in relation to registration. More importantly, the Tribunal found that what Dr Tudor said in his PACE interview was not truthful, in that it was not a true account of his state of mind as to these matters, as to the need for TMM to be registered with the CQC, at the relevant time.

36. In her witness statement, Ms R continued:

"An application for registration to undertake regulated activities of DSP, TDDI and maternity and midwifery was received by the CQC on 20 December 2018… I am aware that a site visit was conducted and as a result of this, the inspectors intended to propose to refuse the application as they had some concerns about patient safety. Tudor Medical Matters were informed of this and they subsequently withdrew their application."

37. It was not clear to the Tribunal precisely when that application was withdrawn. However, the Tribunal was satisfied that it was withdrawn prior to the PACE interview on 8 April 2019, and that Dr Tudor would have been aware of the same. There was a further application for registration for TMM to undertake regulated activities, DSP and TDDI, on 18 April 2019, no doubt prompted by the PACE interview.

38. Ms R went on to explain in her witness statement that:

"…[Dr Tudor] admitted that he was still carrying on with the regulated activities during the application process. I recall that we discussed this with him during the interview and ***I told him that he should not be doing this****…[the Tribunal's emphasis]"*

39. On 17 October 2019, the CQC granted registration for TMM to undertake the regulated activity of DSP only. Registration as not granted for TDDI and on 22 October 2019, a notice of proposal to refuse registration for TDDI was sent to TMM. Ms R stated:

"37…When a Notice of proposal is sent to a service provider, they can submit representations if they do not agree with it. The representations are then sent to a specialist team in the CQC to assess and decide whether to uphold the representations. Many providers often use the notice of proposal as a pointer/guide for things that they can improve on and to make amendments to their service.

38. Tudor Medical Matters submitted representations. The team reassessed Tudor Medical Matters and their representations were upheld, although I should clarify that I was not involved in this process. Tudor Medical Matters was subsequently granted registration for the regulated activity, TDDI on 24 February 2020.

…

40. …Tudor Medical Matters was not registered for TDDI until 24 February 2020 and should not have been carrying on that activity (which includes issuing prescriptions), prior to that date. As far as I am aware, there are no circumstances in which registration for a regulated activity can be backdated."

40. The Tribunal had before it the CQC certificates of registration for TMM to undertake the regulated activity of DSP, date of registration 17 October 2019; and for TDDI date of registration 27 February 2020, with the nominated Individual being Dr Tudor.

41. As stated, the Tribunal did not accept the explanations given by Dr Tudor up to and including the PACE interview. The Tribunal considered that it was highly unlikely for a UK registered doctor, with over forty years of experience, to be so ill informed as to the requirement for CQC registration in his circumstances. He must have been aware that he practised in an extremely heavily regulated sector and had experience of working at Pall Mall Medical, which was a private GP practice. Further, having practised unregulated at TMM since April 2017, he had received a letter from the CQC, dated 12 September 2018, telling him that he was suspected of having committed a criminal offence by reason of not having the proper registration in place. In spite of this, he continued to provide the same regulated medical services as before. This situation did not change having been visited by the CQC on 24 October 2018. In the Tribunal's judgment, this was clear evidence of a wilful disregard for his professional obligations, and of the need to be registered with the CQC.

42. The Tribunal did not accept that Dr Tudor genuinely believed that an application to the CQC would automatically be successful, or that registration would be backdated to the date when the application was originally made, and that an applicant could provide regulated services in the interim period. These purported explanations for his failure defy understanding. It would mean that someone without suitable medical qualifications or experience could make such an application and then start to treat patients before it had been considered by the CQC. The Tribunal simply did not find it credible that Dr Tudor genuinely believed he could carry on practising whilst TMM was not regulated.

43. Even if the Tribunal accepted that Dr Tudor believed that up until the time of the PACE interview that he could continue to practise whilst TMM was unregistered, following that interview he could have been in no doubt that it was a breach of regulations and a criminal offence to do so. The Tribunal accepts, it being unchallenged evidence, that Ms R told Dr Tudor that he could not practice until registration was confirmed. Nevertheless, Dr Tudor continued to see patients straight after the PACE interview and indeed, issued a prescription for Patient A the following day. This was a deliberate and flagrant breach of the regulations, and not an honest mistake, as Dr Tudor characterised his failures in the PACE interview.

44. Following the PACE interview, TMM was prosecuted for two allegations of carrying out regulated activities without having the necessary CQC registration, under Section 10. The case went to court and, on 6 February 2020, as representative of TMM, Dr Tudor pleaded guilty to both the charges. On 18 November 2020, TMM was sentenced and fined £8,000.

Paragraph 46 of the Allegation

> You were responsible for ensuring that TMM was registered with the CQC to carry out regulated activities as defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulations').
> **Found not proved.**

45. The Tribunal noted that this paragraph of the Allegation asserts that Dr Tudor had the responsibility to ensure that TMM was registered with the CQC for regulated activities. In his submission, Mr Morwood had invited the Tribunal to consider that Dr Tudor, as the only doctor at TMM, was the person who was likely to have day to day management and supervision of the provision of regulated medical services under the regulations. Mr Morwood further submitted that Dr Tudor was the only viable choice as the nominated individual (as defined by the regulations) if TMM was to obtain registration. Indeed, it was noted that Dr Tudor was in fact the nominated individual for the purposes of the applications made on TMM's behalf, and was named as such on both registration certificates. It therefore could be inferred that Dr Tudor was the person who had responsibility for ensuring that registration was obtained.

46. The Tribunal had regard to 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014', which state:

> *"6.—(1) This regulation applies where the service provider is a body other than a partnership.*
>
> *(2) The body must give notice to the Commission of the name, address and position in the body of an individual (in these Regulations referred to as "the nominated individual") who is—*
>
> *(a) employed as a director, manager or secretary of the body, and*
>
> *(b) responsible for supervising the management of the carrying on of the regulated activity by the body."*

47. The Tribunal considered it important that the status of TMM as a limited company should not be overlooked. It noted that Dr Tudor was an employee of TMM. As far as the Tribunal was aware, he was not an officer of the company. Mrs AH was sole director of the company. It was she, and not Dr Tudor, who was responsible for decision making on behalf of the company in a legal sense. It may have been that Dr Tudor had some de facto influence over the conduct of the company, but the Tribunal had heard no evidence about this.

48. The Tribunal was satisfied that Dr Tudor, as the only medically qualified person at TMM, was always likely to be the nominated person. However, this was not the same as being the person responsible for ensuring that TMM was registered with the CQC.

49. As the evidence stood, it was difficult to see how an employee of the company could be held legally responsible for ensuring that TMM was registered with the CQC for regulated activities. If he had been an officer of the company, it would have been different. However, the evidence suggested that he was not. The burden in relation to this part of the Allegation, as with all parts, is on the GMC. The Tribunal was satisfied that it had failed to discharge this burden on a balance of probabilities.

50. The Tribunal therefore found paragraph 46 of the Allegation not proved.

Paragraph 47 of the Allegation

> 47. You inappropriately provided diagnostic and screening procedures ('DSP'), a regulated activity, for patients at TMM between 19 July 2017 and 10 September 2019, when TMM did not have the necessary registration with the CQC to carry out DSP, in breach of the Regulations. **Found proved**

51. The Tribunal had before it documentary evidence that Dr Tudor undertook a consultation with Patient A on 19 July 2017 during which Dr Tudor took blood samples for the purpose of external analysis of "B12 / folate and thyroid profile".

52. Dr Tudor undertook a consultation with Patient B on 19 June 2018 during which blood was taken from the "left cubital fossa" for the purposes of external analysis.

53. Dr Tudor undertook another consultation with Patient A on 27 March 2019 when blood was taken from Patient A's "right ACF" for external analysis.

54. These three examples are representative of a large number of similar examples of the regulated activity DSP being provided by Dr Tudor, on behalf of TMM, over the time period set out in the Allegation. The Tribunal was satisfied that this demonstrated that Dr Tudor was providing DSP, a regulated activity, for patients at TMM between 19 July 2017 and 10 September 2019, when TMM did not have the necessary registration with the CQC to carry out DSP, in breach of the Regulations. The Tribunal considered these breaches to be a flagrant disregard for the regulations. For instance, Dr Tudor continued to provide this activity to patients for a period of over 12 months, between receiving the URP letter (warning him that he was committing a criminal offence in September 2018) and obtaining registration for DSP on 17 October 2019. There has been no satisfactory explanation for this.

55. The Tribunal therefore found paragraph 47 of the Allegation proved.

Paragraph 48 of the Allegation

> You inappropriately provided treatment of disease and injury ('TDDI'), a regulated activity, to patients at TMM between 19 July 2017 and 14 February 2020 when TMM did not have the necessary registration with the CQC to carry out TDDI, in breach of the Regulations. **Found proved**

56. The Tribunal had before it documentary evidence that Dr Tudor undertook a consultation with Patient A on 19 July 2017. He prescribed, among other drugs, doxycycline and esomeprazole.

57. Furthermore, Dr Tudor undertook a consultation with Patient A on 4 April 2018. He prescribed a number of drugs including Oestrogel, Co-codamol, Celecoxib and levothyroxine.

58. Dr Tudor also carried out a consultation with Patient A on 30 August 2019. He prescribed, among other things, morphine sulphate and Oestrogel.

59. In addition, there was evidence of a consultation between Patient C and Dr Tudor on 17 January 2020. He prescribed, among other things, levothyroxine and diazepam.

60. The Tribunal was satisfied that these were four examples of a much larger number of instances when Dr Tudor provided treatment of disease and injury, a regulated activity, to patients at TMM between 19 July 2017 and 14 February 2020 when TMM did not have the necessary registration with the CQC to carry out TDDI, in breach of the Regulations. The Tribunal took the same view of this breach, as it had done for paragraph 47. It was satisfied that Dr Tudor had demonstrated a systemic and deliberate determination to ignore the regulations. The Tribunal found that this was, throughout the relevant period, a busy private practice which treated patients on a daily basis, and which had about 1200 patients on its books. As will be seen below, at least some of the instances of the provision of treatment forming the subject of paragraphs 47 and 48 above, also took place in breach of IOT conditions.

61. The Tribunal therefore found paragraph 48 of the Allegation proved.

Interim Orders Tribunal ('IOT') breaches, IOT dishonesty and practising whilst suspended

62. The concerns in respect of Dr Tudor and TMM first came to the notice of the GMC following a referral in December 2018. The first IOT hearing took place on 12 July 2019. Dr Tudor attended and was represented. This Tribunal had regard to the decision of the IOT of 12 July 2019, in which it determined:

> *"17. In all the circumstances the Tribunal considers that there is information to suggest that Dr Tudor may pose a real risk to patient safety if no order were made today, given the multiple serious prescribing concerns raised. Furthermore, it considers that public confidence in the profession may be seriously undermined if Dr Tudor were permitted to continue in unrestricted clinical practice pending the conclusion of the GMC investigation.*
>
> *18. The Tribunal considers that an order of conditions, including a clear protocol for prescribing will provide workable and appropriate safeguards for public protection and is in the public interest, which includes the need to maintain confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour."*

The July 2019 IOT determined to impose conditions on Dr Tudor's registration. Those conditions included:

> *"…*

4 He should not provide medical services from the Tudor Medical Matters clinic until the clinic has had its registration confirmed by CQC

5 He must;

a only prescribe opioids, benzodiazepines, hypnotics and thyroxine once he has communicated with the patient's NHS GP and obtained the relevant medical records from them….

6 He must not prescribe hormone treatments for patients without face to face (in person) consultations with the patients"

63. There was a further IOT hearing on 18 November 2019. Dr Tudor was present and was self-represented at that hearing. This Tribunal noted that there was a continuation of the conditions to address the concerns of the previous IOT in July 2018 and, in particularly, Dr Tudor's promise that there would be no repetition of any of the concerning conduct. The November 2019 determined:

"13. The Tribunal considers that there is information to suggest that Dr Tudor may pose a real risk to public safety if no order were made today, given the multiple serious clinical and prescribing concerns raised. Furthermore, the Tribunal considers that public confidence in the profession may be seriously undermined if Dr Tudor were permitted to return to unrestricted clinical practice at this time pending the conclusion of the GMC investigation.

14. Whilst the Tribunal notes that the order has restricted Dr Tudor's ability to practise medicine it is satisfied that the order imposed is the proportionate response. The Tribunal has noted Dr Tudor's submissions in relation to the circumstances of the incident, including his acceptance of error on his part, and has weighed his assurance that such an incident will not occur again. In these circumstances the Tribunal considers that there is little prospect of repetition. However, the Tribunal has determined to vary the wording of condition 4 in order to clarify the order in the light of the limited registration that has now been awarded to TMM. The conditions are sufficient and are a workable, enforceable and measurable means of addressing the risks identified in this case."

64. The 18 November 2019 IOT varied the conditions imposed on Dr Tudor's registration which included the following condition.

"4 He should not provide medical services from the Tudor Medical Matters clinic until the clinic has had its registration confirmed by CQC for those services"

65. There was a further IOT on 6 January 2020. Dr Tudor was in attendance and was represented by Mr Richard Dawson, Counsel. It had come to the attention of the IOT that it

had been alleged that Dr Tudor had made out a prescription for a patient, who was referred to as 'Patient O', on 26 November 2018.

66. This Tribunal noted with some interest the transcript from the IOT hearing of the January 2020 IOT and the submission made on behalf of Dr Tudor, in which it was stated:

> *"…Dr Tudor accepts he issued that prescription and 'holds his hands up' accepting that he shouldn't have done so. It was a single prescription and indeed it is the only prescription that he has issued in the circumstances. It was issued to a young man, a previous patient of his private GP practice, Tudor Medical Matters, a young man who had originally been taken into hospital care with a heart complaint likely caused by drug misuse but ultimately released from hospital here in Manchester with a prescription for the beta blocker drug that Dr Tudor continued to prescribe for him on a private basis.*
>
> *The original prescription issued by the hospital was of considerable age, long before allegations had been raised with the General Medical Council and indeed was a private patient under Dr Tudor's care at a stage long before these allegations had been raised with the GMC. It is Dr Tudor's belief that this young man did not have an NHS general practitioner he was specifically registered with. He came to Dr Tudor through the conduit of other family members who themselves were patients of Dr Tudor and had made that recommendation, and had been under Dr Tudor's care before these allegations were levelled and conditions were imposed upon his practice. He had not seen him in some little time but as of the date of the prescription, 26 November 2019, Dr Tudor was at the private practice premises, Tudor Medical in Rawtenstall performing administrative tasks, dealing with staff wages and the like. The practice in and of itself effectively was unworkable because of the restrictions on his practice but staff members were still present and working effectively in order to tell members of the public that they weren't able to offer appointments and weren't able to take on new patients at that time. He was there simply in the context of carrying out administrative work.*
>
> *XXX, as I think you will appreciate from some of the adjournment documentation that came at the back end of 2019, at that time had recently had XXX, on 24 November, and that was a matter preying on his mind at that time, but he was present at the practice performing administrative tasks when this young man presented himself and made complaint that he had run out of the tablets which were essential for the treatment of his heart complaint. He effectively caught Dr Tudor on the hop and, feeling that he had no real alternative and not wishing to send him on his way without a prescription to deal with that known heart complaint and fearing that if he were to do so there may be serious ramifications and his life may very much be at risk, and in hindsight, he foolishly, but at the time believing himself simply to be a caring and considerate doctor, issued that one and only prescription.*
>
> *…*

…Dr Tudor instructs me that since the November hearing in real terms he has done very little work at all. He has worked two Mondays for Pall Mall Medical and he has done a very small amount of medico-legal work, two reports in all. Other than that, there has been no particular medical work. His life has been occupied primarily by XXX and dealing with the stress that these proceedings have brought. He would like to work to a greater degree but, of course, the nature of the restrictions as they currently stand, given the lack of extended registration with the CQC to allow him to treat disease and injury, his function as a general practitioner to all intents and purposes is curtailed and until that is resolved his practice is so restricted that fundamentally he cannot work. His income has plummeted, understandably and inevitably by those restrictions.

…Albeit, the issuing of that prescription was plainly wrong, seen in its proper context, in my submission, it can be seen as a one-off not to be repeated. The conditions are otherwise performing their necessary tasks and to move above and beyond them to the ultimate sanction of suspension from practice in my submission is unnecessary and too onerous. The risk which he might present can be properly managed by way of conditions. Really the issue of registration with the CQC is the stumbling block which now presents itself, but he has sought in every other sense to abide by the conditions cognisant of the requirements therein."

67. The January 2020 Tribunal determined:

"23. The Tribunal considers that there is information to suggest that Dr Tudor may pose a real risk to public safety if no order were made today, given the multiple serious clinical and prescribing concerns raised. Furthermore, the Tribunal considers that public confidence in the profession may be seriously undermined if Dr Tudor were permitted to return to unrestricted clinical practice at this time pending the conclusion of the GMC investigation

24. The Tribunal has considered the new information provided by Dr V and has concluded this provides insufficient information to consider that there had been a breach of the conditions. The information provided is non-specific in relation to patient identity and dates. It notes that Dr Tudor has conceded issuing a prescription, as alleged by Mr U when he should not have done so. It has taken account of the background provided in relation to this matter. The drug Dr Tudor has admitted to prescribing is not a controlled drug and was a drug that Dr Tudor was aware had been previously prescribed for the patient by the hospital. The Tribunal was concerned that the issuing of such a prescription was in breach of the interim conditions. However, it determined that the strengthening and clarification of the conditions would manage the current risk to members of the public and the public interest."

68. The January IOT took account of the new information and that he had conceded that he had issued the prescription for Patient O and should not have done so. The IOT varied his conditions, which included the following conditions:

> *"4 He must not provide medical services from the Tudor Medical Matters Clinic including Diagnostic and Screening procedures and Treatment of disease, disorder or injury unless the clinic has had its registration for these activities confirmed by the CQC.*
>
> *…*
>
> *6 He must:*
>
> *a not prescribe thyroxine unless he has communicated with the patient's NHS GP and obtained the relevant medical records from them."*

69. There was a further IOT hearing on 18 February 2020. Dr Tudor was present and he was represented by Mr Dawson, Counsel. That IOT hearing was prompted by a number of further concerns.

> *"5. On 2 January 2020, Mr AM, HR & Compliance Assistant at Pall Mall Medical, provided the GMC with medical records; copies of two prescriptions (22 October 2018 and 12 November 2018) issued by Dr Tudor;*
>
> *6. On 13 January 2020, Dr AN, of the Waterfront Medical Practice at Rossendale, informed the GMC that a female patient (Patient I) had consulted with him about prescriptions that she had been given by Dr Tudor as she was finding these prohibitively expensive to buy. Dr AN provided details of the medication prescribed by Dr Tudor which included Levothyroxine, Methotrexate and Thyroxine…."*
> *…*
>
> *24. In relation to the prescriptions bearing the stamps of Dr Tudor's company, Mr Dawson explained that when Dr Tudor initially set up Tudor Medical Matters as a limited company, he worked as an employee of the company. However, Dr Tudor later decided to work for himself under the name 'Dr Gary Tudor Clinic', albeit at the same address as Tudor Medical Matters Ltd. Mr Dawson said that had Dr Tudor not done so, he would not have been subject to the requirements of the CQC. He said that Dr Tudor did not realise that he was subject to certain requirements of the CQC. Mr Dawson said that he could not offer any explanation for why the CQC logo appeared on one of the prescriptions.*
>
> *25. Mr Dawson admitted, on behalf of Dr Tudor, that there has been a breach of condition 4. He said that Dr Tudor recognised the GMC's concern and in order to alleviate the concern, Dr Tudor has today shut down Tudor Medical Matters Ltd as a*

medical services provider and has instructed his staff to cancel all patients' appointments.

…

27. The Tribunal has determined that, based on the information before it today, there are concerns regarding Dr Tudor's fitness to practise which may pose a real risk to members of the public and which may adversely affect the public interest. After balancing Dr Tudor's interests and the interests of the public, the Tribunal has decided that an interim order remains necessary to guard against such a risk.

28. In reaching its decision, the Tribunal took into account the serious concerns raised in relation to Dr Tudor's clinical practice. The Tribunal was satisfied, on the balance of probabilities, that Dr Tudor had breached the conditions previously imposed upon him, by his own admission and by the ponderance of information before it. The Tribunal has received information, which Dr Tudor accepts, that he prescribed potentially harmful and dangerous, controlled drugs, in breach of the terms of his conditions. The Tribunal was particularly concerned that Dr Tudor has continued to issue prescriptions for those drugs specified in his conditions in the absence of patients' medical records. The Tribunal determined that Dr Tudor has shown a wilful disregard for the conditions imposed by previous Tribunals on his registration.

*29. **The Tribunal was satisfied that Dr Tudor showed a flagrant and systematic disregard for the interim conditions imposed upon his registration.** The Tribunal noted that this is the third occasion on which Dr Tudor has appeared before an Interim Orders Tribunal for alleged breaches of his conditions. By his own admission, he has breached the substance and spirit of condition 4 by providing medical services to patients from the Tudor Medical Matters Clinic. He has further breached conditions 5 and 6 by failing to notify the patients' NHS GP's and not providing a log to this Tribunal of any such prescriptions issued, as required of him. The Tribunal was not satisfied with the explanation provided as to why Dr Tudor was unable to provide the logs as required by conditions 5 and 6. The Tribunal concluded that Dr Tudor presented a risk to patient safety."*

70. The February 2020 IOT determined to suspend Dr Tudor's registration to be reviewed within 3 months.

Paragraphs 36(a)-(c) of the Allegation

On:

(a) 12 July 2019 at an IOT hearing, your General Medical Council ('GMC') registration was made subject to the following conditions:

(i) 'you should not provide medical services from [Tudor Medical Matters ('TMM')] until the clinic has had its registration confirmed by the Care Quality Commission ('CQC') ('Condition 1'); Found proved

(ii) 'you must only prescribe opioids, benzodiazepines, hypnotics once you have communicated with the Patient's NHS GP and obtained the relevant medical records from them ('Condition 2'); Found proved

(iii) 'you must not prescribe hormone treatments without face to face (in person) consultations with the Patients ('Condition 3'); Found proved

(b) 18 November 2019, the IOT amended Condition 1 to 'you must not provide medical services from [TMM] until the clinic has had its registration confirmed by the CQC for those services' ('Condition 4'); Found proved

(c) 6 January 2020, the IOT amended:

(i) Condition 3 to 'you must not prescribe thyroxine unless you have communicated with the Patient's NHS GP and obtained the relevant medical records from them' ('Condition 5'); Found proved

(ii) Condition 4 to 'you must not provide medical services from [TMM] clinic including diagnostic and screening procedures or the treatment of disease, disorder or injury unless the clinic has had its registration for these activities confirmed by the CQC' ('condition 6'). Found proved

71. In respect of paragraph 36b, the Tribunal noted that Condition 1 in the allegation read 'you *must* not…', when it should have read 'you *should* not…' to reflect 'Condition 4' which was imposed by the IOT on 18 November 2019. This Tribunal considered that this was a typographical error in the drafting of paragraph 36b of the Allegation and that it did not fundamentally undermine the material content of the allegation.

72. Otherwise, the Tribunal found paragraph 36 found proved. The Tribunal accepts the matters set out in the determinations of the various IOT's, and has taken the trouble to set them out in some detail above. The content of the determinations has not previously been challenged, and it was not challenged during the course of this hearing.

Paragraph 37 of the Allegation

Between 30 July 2019 and 26 May 2020 you breached one or more of the IOT conditions referred to in paragraph 36 as set out in Schedule 11.

Found proved

73. In dealing with this part of the allegation, the Tribunal took issue with the time period adopted in the wording of the paragraph i.e the period between which the conditions imposed by the IOT's were allegedly breached. Dr Tudor had been suspended by an IOT from 18 February 2020. It was the Tribunal's view that conditions imposed prior to this date, ceased to be in force once the suspension was imposed, and that therefore any provision of medical services occurring after 18 February 2020, could not be considered as a breach of the conditions. Mr Morwood confirmed that he agreed with this approach. For this reason, the Tribunal disregarded the final three events in Schedule 11 of the Allegation.

74. There was doubt in the Tribunal's mind as to what happened after the original three month period of the suspension had expired. It heard no evidence on this point. It therefore refused to make findings on the Allegation based on events after 17 May 2020.

75. Having further regard to Schedule 11, the Tribunal noted that on 17 January 2020 and 24 January 2020, it was alleged that Dr Tudor provided regulated services to Patient R. The Tribunal was not provided with the medical notes of this patient. The Tribunal therefore felt unable to reach findings on these aspects of the Allegation.

76. The Tribunal was satisfied that it had before it evidence that Dr Tudor had breached one or more of that which is set out in respect of Schedule 11, between 30 July 2019 and 18 February 2020. By way of example, on 31 July 2019, Patient A consulted with Dr Tudor and he prescribed a number of drugs including methotrexate and morphine sulphate in breach of "Condition 1". On 18 September 2019, Dr Tudor issued a repeat prescription without a face-to-face consultation, for drugs such as levothyroxine and diazepam, in breach of "Condition 1, 2 and 3". having prescribed diazepam, a benzodiazepine, Dr Tudor had failed to notify the patient's NHS GP, and had failed obtain the patient's medical records. On 17 January 2020, Dr Tudor held a consultation with Patient C, and similarly prescribed diazepam in breach of "Condition 2". Dr Tudor had also breached "Condition 5" by failing to notify the NHS GP and obtain Patient C's medical records. The issuing of a prescription constituted the provision of TDDI outside of registration.

77. The above are three examples of a large number of breaches. The Tribunal noted that there were 26 breaches in Schedule 11 occurring between the first and second IOT hearing. There were 6 occasions of breaches between the second and third IOT hearings, and there were four breaches between the third and prior to the fourth IOT, when the conditions were replaced with a suspension on 18 February 2020. Again, Dr Tudor's breaches in this regard were numerous, persistent, and flagrant.

Paragraph 39 of the Allegation

Your actions as described at paragraph 37 and Schedule 11 were dishonest by

reason of paragraph 38. **Found proved**

78. The Tribunal first considered the relevant legal test for dishonesty as set out in the case of Ivey v Genting Casinos (UK) Limited [2017] UKSC 67, which states:

> *"74. When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest."*

79. Therefore, the Tribunal had to ascertain (subjectively) the actual state of Dr Tudor's knowledge or genuinely held belief as to the facts at the material time. If this is established, the Tribunal would have to decide whether this was dishonest by (objective) standards of ordinary decent people. If this is not established, then the Allegation would not be proved.

80. As already found, Dr Tudor was aware of the conditions and that by continuing to practice, he was in breach of the conditions to varying degrees. He knew that conditions had been imposed to protect patient safety, and the reputation of the profession. It seems likely that, notwithstanding the unreasonableness of his state of mind, that Dr Tudor profoundly disagreed with this assessment of his practising methods, and believed that he could still continue to provide the same services to his patients. However, looked at objectively, this Tribunal found that this position was unsustainable. By continuing to practise in breach of the conditions imposed by the IOT, he was behaving in a way which was dishonest by the standards of ordinary decent people.

81. Firstly, he was misleading the GMC, his professional regulator. The IOT determinations are clear, in that Dr Tudor was repeatedly promising to comply with restrictions imposed, as he was professionally obliged to do. During the hearings, Dr Tudor provided reasoning such as the breaches were isolated incidents, that they were a 'one offs'. He tried to characterise his breaches as ones caused by situations outside of his control, and that he was doing 'good acts'. He said that his conduct of breaching his conditions would not happen again. The Tribunal was satisfied that these submissions were largely false.

82. Secondly, he was treating patients who would have believed that Dr Tudor was entitled to provide the services. In doing so in breach of his professional obligations, and at a time when he was prevented from doing so by conditions, he was fundamentally misleading his patients, in breach of *Good Medical Practice (2013)* (GMP), and thereby potentially putting them at risk. Dr Tudor was also risking the reputation of the profession by acting as he did.

83. The Tribunal determined that Dr Tudor's actions in breaching his conditions, which were put in place to maintain patient safety, undermined patient safety, public confidence in the profession the public, the CQC and the GMC.

84. The Tribunal was of the view that in the terms set out, and in the knowledge of all the factors in this case, an ordinary decent person would consider Dr Tudor's actions to amount to dishonesty.

85. The Tribunal therefore found paragraph 39 of the Allegation proved.

Paragraph 40 of the Allegation

> You instructed your legal representative to falsely state, at an IOT review hearing on 6 January 2020, that the prescription you issued to Patient O on 26 November 2019, referred to in Schedule 11, was 'a single prescription and indeed it is the only prescription he has issued in the circumstances'.
> Found proved

86. As already stated, the IOT on 6 January 2020, was told that Dr Tudor admitted issuing a prescription to Patient O on the 26 November 2019 in breach of "Condition 4" in that it was the issuing to a prescription when TMM still did not have TDDI registration. Mr Dawson of counsel represented Dr Tudor on this occasion, who characterised the breach as being a "one off". He went on to state that it was "a single prescription and indeed it is the only prescription he had issued in the circumstances. Indeed, Mr Dawson went further than this, as set out above. In particular, it was variously suggested that TMM has ceased to practice since the conditions were imposed by the IOT and that the prescription to Patient O had been the only medical work he had done since November save for working two Mondays for Pall Mall Medical and two medico-legal reports. He said Dr Tudor otherwise sought in every other sense to abide by the conditions, which were providing all of the necessary safeguards.

87. These representations need to be looked at in the context of Schedule 11, an examination of which demonstrates that the representations made on behalf of Dr Tudor, and upon his instructions, were grossly untrue. Between the IOT hearing on 12 July 2019 and IOT hearing on 6 January 2020, there had been at least 33 occasions when Dr Tudor had provided regulated medical services in breach of his conditions, the prescription on 26 November 2019 being just one of those occasions.

88. Since the second IOT on 18 November 2019, there had been four occasions, including the issuing of a prescription for Patient O on 26 November 2019 where regulated services were undertaken. The Tribunal was of the view that the actions as set out in Schedule 11 demonstrated a flagrant and systematic breach by Dr Tudor. It was the Tribunal's judgment that as of 6 January 2020, TMM and Dr Tudor were continuing to practice unabated. It was business as usual.

89. Accordingly, the Tribunal determined that, on any view, Dr Tudor had instructed his legal representative to falsely state that the prescription he issued to Patient O on 26 November 2019, referred to in Schedule 11, was 'one off'. There is no suggestion that Mr Dawson stated any of these matters outside of instructions from Dr Tudor. As such, The Tribunal is entitled to infer that what Counsel said was based upon his instructions.

90. The Tribunal therefore found paragraph 40 of the Allegation proved.

Paragraph 41 of the Allegation

> When you instructed your legal representative to make the statement set out at paragraph 40 you knew you had also issued one or more other prescriptions between 12 July 2019 and 6 January 2020, as set out in Schedule 11. **Found proved**

91. The Tribunal was of the view that it must have been apparent to Dr Tudor that when he gave his instructions to Mr Dawson that they were false given that Dr Tudor continued to practise and prescribe as a private GP at TMM in much the same way as he had always done.

92. The Tribunal therefore found paragraph 40 of the Allegation proved.

Paragraph 42 of the Allegation

> Your actions described at paragraph 40 were dishonest by reason of paragraph 41. **Found proved**

93. The Tribunal was satisfied the Dr Tudor's state of mind, as set out above, was dishonest by the standards of ordinary decent people. By making grossly false statements to his regulator, the GMC, in the context of important regulatory proceedings, he knew that he was likely to distort the outcome in his favour, or was attempting to do so. It is clear from the determination of the IOT on 6 January 2020 that the false representations did impact upon the outcome in that it was persuaded to persevere with conditions when, had it known the truth, it was likely to have suspended Dr Tudor. This risked the safety of patients and the reputation of the profession. The Tribunal considered Dr Tudor's actions in this regard to be a further example of Dr Tudor's flagrant disregard for the CQC and the GMC, and for the welfare of patients and the profession at large.

94. The Tribunal therefore found paragraph 40 of the Allegation proved.

Paragraphs 43(a) and (b) of the Allegation

> You:
>
> (a) had your registration with the GMC suspended by the IOT between 18 February 2020 and 5 May 2020; **Found proved**

(b) provided clinical care to patients between 2 March 2020 and 5 May 2020 as set out in Schedule 12. **Found proved**

95. In respect of paragraph 43a, the Tribunal was satisfied, as set in detail above, that Dr Tudor's registration was suspended by an IOT on 18 February 2020. It was further satisfied, for the reasons set out, that Dr Tudor was aware of the same.

96. In relation to Schedule 12, the Tribunal disregarded references to Patient R's care, as it had not been given a copy of Patient R's medical records. The Tribunal also disregarded the 3 March entry re. Patient C, as it appeared to be an error, there being no corresponding entry on that day in Dr Tudor's medical records. Otherwise, by reference to Dr Tudor's medical records and the relevant patients, the Tribunal was satisfied that the alleged instances in Schedule 12 were occasions upon which Dr Tudor had provided medical care during the period of his suspension.

97. In relation to this part of the Allegation, the Tribunal had regard to an email sent from Dr Tudor to the GMC, on 17 January 2023, in which he made representations about work he had carried out whilst he was suspended by the IOT, and in which he stated:

> *"The MPTS has alleged that I have worked as a Doctor whilst suspended which is blatantly untrue. I did not go near the clinic whilst suspended so I am somewhat shocked. There is a printout in respect of Consultations during the suspension period that has been provided by Ms AB which refers to "Gary" as the consulting doctor. I understand that she has sent a letter of explanation.*
>
> *In the clinic, I have always been referred to formally as Dr. Tudor NOT Gary.*
>
> *I have access to the old clinic records and can provide the MPTS with an adequate explanation.*
>
> *If possible would be grateful if you could send me a copy of that printout."*

98. Sent with that email were four prescriptions with the name Dr AE on them, dated 2 March 2020, 10 March 2020, 23 March 2020 and 5 May 2020. It was not clear to which the patients these prescriptions had been issued. Additionally, among the attached documents were screen shots which appeared to be of TMM's diary.

99. In his email, Dr Tudor referred to a letter from a Ms AB, an employee XXX, dated 4 June 2020. It stated:

> *"It was an oversight on my part that the locum did not have his own account on our booking system. I wrongly assumed that it would automatically generate his name by adding a booking column on the diary.*

I can confirm that the session notes, prescriptions were issued by Dr AE (GMC: XXX) in the month of March/ April 2020.

This has now been rectified and the locum GPs now have their own account generating their name on the system."

100. In broad terms the suggestion by Dr Tudor appeared to be that some or all of the instances of treatment which appear in Schedule 12 (i.e when Dr Tudor provided regulated services when under suspension) were actually provided by Dr AE. So far as the Tribunal could ascertain, it was further being suggested that TMM's record system did not allow an entry to be placed alongside the patient's notes to reflect this fact. The suggestion was that the column would always be populated by some reference to Dr Tudor, by way of default.

101. One of the ongoing difficulties that the Tribunal had in this case was to work out what, if any, argument Dr Tudor had presented in his own defence to any aspect of the Allegation, and then to make findings as to the weight to be attached to such arguments. The Tribunal found that it was fair to have some regard to Dr Tudor's responses at the 'Rule 4' and 'Rule 7' stage of proceedings. The Tribunal was also satisfied that it was fair to have some regard to the emails and documents sent to the GMC, and thereafter the Tribunal, on 17 January 2023, albeit after the hearing had been running for about a week.

102. The Tribunal agreed that caution was required when assessing what weight to apply to such evidence. Dr Tudor having chosen not to attend, was not available to expand upon his evidence, or to be challenged about it in cross examination. None of his responses were formal documents in the sense that they were witness statements with statements of truth. The same applied to, for instance, Ms AB's letter above, who doubtless was a person with a personal interest in this case. The Tribunal also agreed that if one analysed the submissions of Dr Tudor, that there was evidence of inconsistency, and of an attempt to mould responses to fit the GMC's case as it unfolded. All of these factors caused the Tribunal to be very cautious when placing reliance on Dr Tudor's evidence. In large part, the Tribunal placed little if any weight on it.

103. A good example of this is Dr Tudor's submissions relating to the occasions relied upon by the GMC in Schedule 12. During the course of this case, the Tribunal has become very familiar with the form and content of Dr Tudor's and TMM's patient notes. In part, they comprise of a column which is headed "who". The Tribunal found that this column is intended to be populated with the name of the person carrying out the activity. The Tribunal has looked at hundreds of entries, over a 4 year period, and found that all save for one or two, were populated by the entry "Gary". The Tribunal found that where the name "Gary" appears alongside an entry, that it was carried out by Dr Tudor. It is not surprising that his name should appear alongside the vast majority of entries, because he was the only regular doctor employed by TMM.

104. In relation to Schedule 12, all of the entries have "Gary" as the doctor undertaking the activity on the system, save for 23 April 2020, which has 'Dr Tudor' beside it. The Tribunal

also finds that this was on occasion when Dr Tudor was likely to have been the treating doctor.

105. It is not clear how the "who" column was populated. The Tribunal heard no evidence about this in the absence of Dr Tudor or someone else involved in the practice. The Tribunal found that it was likely that the person performing the activity was able to enter their name. Firstly, were it not the case, then it would make little sense to have the entry at all. As it is, the Tribunal is satisfied, that it is important to know who has treated a patient. Secondly, the entry "Dr Tudor" on 23 April 2020 bears out that the name can be changed. Again, for it to be otherwise would make little sense. The Tribunal does not accept that the column defaults to "Gary", if that be Dr Tudor's case.

106. In this regard, the Tribunal also considered an entry in patient records relating to Patient K on 27 June 2019, when a repeat prescription is noted in the TMM diary system with the name "Ms AB" as the person who undertook the activity. The Tribunal noted that this was clearly a member of staff at TMM who is XXX and XXX. The Tribunal was satisfied, firstly that Ms AB had made this entry, and that she had been able to place her own name alongside the record, in June 2019. This gives the lie to the suggestion that TMM records did not allow this until sometime in 2020. The Tribunal was not therefore persuaded that the system only populated the name 'Gary' in the column headed "who" regardless of the person who undertook an activity. It was satisfied that if another doctor had treated patients at TMM, then they could have indicated as such against the relevant entry in the patient's notes. It therefore finds that the email from Dr Tudor, and the letter from Ms AB, to this effect, are unreliable.

107. The Tribunal having found that Dr Tudor was not a reliable source of information on the point above, it was particularly cautious in placing weight on documents attached to the unreliable email. The Tribunal was asked to accept that the prescriptions were issued by a Dr AE. However, it had no evidence as to who Dr AE was, nor evidence from Dr AE directly. The prescriptions are not signed. The diary entries do suggest that a Dr AE was carrying out work for TMM at the relevant time. However, there is no explanation of these entries, and they are not exhibited to a witness statement and/or a statement of truth. In the circumstances, the Tribunal could not be clear about what they could infer from the diary entries, or be satisfied that they were genuine and contemporaneous documents. The Tribunal also noted that there were entries from Dr Tudor during the period that he was suspended from practise.

108. The Tribunal was therefore of the view that it could place little weight on the email from Dr Tudor, its attached documents, or the letter from Ms AB.

109. The Tribunal also had regard to a letter sent to Dr AD, Consultant Rheumatologist, dated 16 March 2020, from Dr AE, relating to a referral of patient A, in which it is stated:

> *"Thank you for seeing this pleasant 73-year-old housewife who suffers inflammatory arthritis. Previously this condition has been well controlled with Methtrexate 12.5mg per week but because of Methtrexate has to be initiated by a consultant rather than a*

GP, I have been forced to stop prescribing it for her and inevitably her symptoms have returned. I would be grateful for your help going forwards."

110. In his Rule 7 response, Dr Tudor stated in relation to the referral to Dr AD of patient A:

"I referred her to a consultant Rheumatologist who in fact agreed with my diagnosis of Rheumatoid/ Osteoarthritis and advised continuing to treat her with Methotrexate and Prednisolone."

111. The Tribunal considered found that the letter to Dr AD and the related part of Dr Tudor's Rule 7 response suggest that it was he who had made the referral, and was still treating patient A, at a time when he was suspended. This is clearly inconsistent with the email sent on 17 January 2023. This further undermined the credibility of this part of Dr Tudor's case.

112. The history of Dr Tudor's level of compliance with the CQC, and how his attitude towards the GMC's attempts to restrict his medical practice were, until his suspension in February 2020, demonstrated a flagrant and systematic disregard. The Tribunal were not persuaded that Dr Tudor's attitude to the suspension of his registration would have been any different.

113. The Tribunal determined that, on the balance of probabilities, Dr Tudor knew that, when he provided the clinical care described in paragraph 43(b) and Schedule 12, his GMC registration was suspended as described in paragraph 43(a) and that the suspension of his GMC registration meant that he should not provide clinical care.

114. The Tribunal therefore found paragraph 43 of the Allegation proved.

Paragraphs 44(a) and (b) of the Allegation

When you provided the clinical care described in paragraph 43b and Schedule 12 you knew:

(a) your GMC registration was suspended as described in paragraph 43a; **Found proved**

(b) that the suspension of your GMC registration meant that you should not provide clinical care. **Found proved**

115. The Tribunal therefore found paragraphs 44(a) and (b) of the Allegation proved, for all of the reasons set out above. The Tribunal was satisfied that there were clear issues of patient safety which precluded Dr Tudor from providing clinical care when he was suspended.

Paragraph 45 of the Allegation

45. Your actions described at paragraph 43b where dishonest by reason of paragraph 44. **Found proved**

116. The Tribunal was satisfied that, in the knowledge of all the pertinent facts in this case an ordinary decent person would consider Dr Tudor's actions as described at paragraph 43b to amount to dishonesty by reason of paragraph 44. His conduct was dishonest in relation to the IOTs, his regulator, and in relation to his patients, who would have assumed, when consenting to treatment, that he was someone who was lawfully able to provide clinical care. By behaving as he did, the Tribunal considered Dr Tudor's actions in this regard to have placed patients in clear and serious danger, to have jeopardised the reputation of the profession, and to be a further example of Dr Tudor's flagrant disregard for his obligations as a doctor.

117. The Tribunal therefore found paragraph 45 of the Allegation proved.

Core Themes in respect of Patients A - I

118. During the course of its deliberations, the Tribunal identified that there were some core themes common to a number of patients. It decided that it would be appropriate to make findings about these core themes, and then to apply those findings when considering the individual allegations. The core themes identified by the Tribunal were the diagnosis of hypothyroidism and its treatment with levothyroxine; and the diagnosis of rheumatoid arthritis and its treatment with methotrexate.

119. In arriving at its findings in relation to the core themes, and later, as to the appropriateness of treatment provided to the individual patients, the Tribunal tended to place significant weight on the opinions of Dr AC, the GMC expert witness. Dr AC had considerable skill and experience from practising as a GP since the 1990's. The Tribunal found that he had set out his views in the three reports provided to the Tribunal in a coherent and consistent manner. The same applied to his oral testimony. Moreover, where relevant, Dr AC's opinion was consistent with applicable guidance such as the national Institute for Health and Care Excellence (NICE) Guidelines, the Shared Care Protocol for the administering of methotrexate in Dr Tudor's region, the British National Formulary (BNF), and in the leaflet 'NHS: National Patient Safety Agency – Methotrexate treatment'.

120. Furthermore, the Tribunal found that there had been no material challenge to the evidence of Dr AC. Dr Tudor had been given the opportunity during the case management stages of proceedings to ask questions of Dr AC, and to instruct his own expert witness, if he wished to do so. Dr Tudor had chosen to do neither, at a time when he had legal representation. Moreover, Dr Tudor had chosen not to attend the hearing, and had therefore not put any questions to Dr AC by way of cross-examination. The Tribunal agreed that in the circumstances, it would need very good reasons to diverge from the expert opinion expressed by Dr AC. It has been careful not to substitute its own opinions for those expert opinions expressed by Dr AC. Where the Tribunal has found parts of the Allegation relating to

individual patients not proven, it has done so based on a differing interpretation of the factual evidence, and on one occasion, where it appeared the Dr AC re-siled from his original opinion about an issue. Of course, issues of fact are for the Tribunal, and the Tribunal alone.

Hypothyroidism

121. The Tribunal had regard to The Royal College of Physicians (RCP) guidance: The diagnosis and management of primary hypothyroidism, dated 14 June 2011, which states:

> *"The diagnosis and management of primary hypothyroidism*
>
> *Hypothyroidism, underactivity of the thyroid gland, is common. It can make people unwell and should be treated with levothyroxine tablets, a synthetic form of the thyroid hormone thyroxine (also abbreviated to T4). Symptoms of hypothyroidism, for example tiredness, are not specific to underactivity of the thyroid gland, and occur in many other situations. It is important to diagnose hypothyroidism with a blood test, because it can be dangerous to take levothyroxine or other thyroid hormones if they are not needed. We are therefore very concerned that some patients with and without thyroid dis-ease are being inappropriately diagnosed and managed, using levothyroxine and other thyroid hormones, in ways which compromise patient safety. This is potentially an enormous problem, given that, in any one year, one in four of the population have their thyroid function checked.*
>
> *The vast majority of patients with suspected thyroid disease are supported very well in primary care by their GPs, and their condition, hypothyroidism or otherwise, is appropriately diagnosed and well managed. However, some patients are inappropriately diagnosed as being hypothyroid (often outside the NHS) and are started on levothyroxine or other thyroid hormones, which will not only cause them possible harm, but leaves the true cause of their symptoms undiagnosed and therefore untreated. This statement refers only to primary hypothyroidism. Secondary hypothyroidism is a different condition and should be managed by accredited endocrinologists in the same way as all other diseases of the pituitary gland.*
>
> *Diagnosis of primary hypothyroidism*
>
> *(a) The symptoms of hypothyroidism are very common, both in many other conditions and even in states of normal health. It is therefore essential that thyroid function is tested biochemically alongside a careful clinical assessment of the individual patient. Clinical symptoms and/or signs alone are insufficient to make a diagnosis of hypothyroidism.*
>
> *(b) The only validated method of testing thyroid function is on blood, which must include measurement of the levels of thyroid stimulating hormone (TSH) and free thyroxine (FT4) in serum.*
> *.....*

(d) The results of blood tests for thyroid function can be influenced by other factors, for example in some illnesses which do not permanently damage the thyroid gland. In this case the tests will return to normal after the illness and thyroid hormone therapy is not needed (and can be harmful).
….

Treatment of primary hypothyroidism

(a) The aim of the treatment of hypothyroidism is to render the patient back to the normal or 'euthyroid' state.

(b) When a sufficient dose of thyroid treatment is given to lower the TSH to within the normal range (reference range) for the test method used, patients usually recover from their symptoms of hypothyroidism.

(c) Fine-tuning of TSH levels inside the reference range may be needed for individual patients.

(d) Patients with continuing symptoms after appropriate thyroxine treatment should be further investigated to diagnose and treat the cause.

(e) Overwhelming evidence supports the use of thyroxine (T4 or tetraiodothyronine) alone in the treatment of hypothyroidism, with this usually being prescribed as levothyroxine. ….

(f) There are potential risks from T3 therapy, using current preparations, on bone (eg osteoporosis) and the heart (eg arrhythmia). We note that the extract marketed as Armour Thyroid contains an excessive amount of T3 in relation to T4. Overtreatment with T4, when given alone, has similar risks.

Treatment of sub-clinical hypothyroidism

(a) Sub-clinical hypothyroidism is defined as being present in a patient when the TSH is above the upper limit of the reference range (but usually less than 10mU/L) and free T4 levels are within the reference range.

(b) Some patients with sub-clinical hypothyroidism, particularly those whose TSH level is greater than 10mU/L, may benefit from treatment with levothyroxine in the same way as for clinical hypothyroidism, as indicated in national guidelines …

Patients with normal thyroid function tests

(a) We recommend that those patients whose thyroid blood tests are within the reference ranges but who have continuing symptoms, whether on levothyroxine or not, should be further investigated for the non-thyroid cause of the symptoms.

(b) A further opinion or help with these patients may be sought from appropriate specialists on specialist registers of the Royal College of Physicians or the Royal College of Paediatrics and Child Health.

Summary

(a) Patients with suspected primary hypothyroidism should only be diagnosed with blood tests including measurement of serum TSH.

(b) Patients with primary hypothyroidism should be treated with T4 using levothyroxine tablets (listed in the British National Formulary) alone.

(c) There is no indication for the prescription of levothyroxine or any preparation containing thyroid hormones to patients without an established diagnosis of thyroid disease and thyroid blood tests within the reference ranges.

(d) In patients with suspected primary hypothyroidism there is no indication for the prescription of levothyroxine or any preparation containing thyroid hormones to patients with thyroid blood tests initially within the normal range. Thus patients with normal levels of T4 and TSH do not have primary hypothyroidism, and even if they have symptoms which might suggest this, they should not be given thyroid hormone replacement therapy.

….

(h) The above statements reflect best practice of clinical endocrinologists accredited by the Royal College of Physicians and the Royal College of Paediatrics and Child Health"

122. Dr AC assisted the Tribunal as to what hypothyroidism is, how it can be diagnosed and how it can be treated. He told the Tribunal that the thyroid is a gland in the neck which helps regulate metabolism. If the thyroid gland is not working properly then a person's metabolism tends to become slower and less active. The function of the thyroid gland is to produce one hormone, thyroxine. He said that the thyroid gland was regulated by the hypothalamus.

123. Dr AC explained that there were two hormones that were primarily involved with diagnosing thyroid disorders, thyroxine, and the thyroid stimulating hormone (TSH), produced by the hypothalamus. If the thyroid gland was not working well, then the thyroxine level would drop and the hypothalamus would increase the production of TSH, so that the

TSH level would go up as the thyroxine level went down. This is a form of hypothyroidism. If the TSH level is low and the thyroxine level is high, this is a form of hyperthyroidism.

124. Dr AC said that hypothyroidism causes symptoms such as feeling cold or tired. These symptoms are very common to many other conditions, which means that these symptoms should not be relied upon when making a diagnosis of hypothyroidism.

125. Dr AC told the Tribunal that hypothyroidism can only be safely diagnosed by reference to results of blood tests and that this was clearly set out in the guidance from the RCP.

126. It was Dr AC's view that it was inappropriate to base a diagnosis of hypothyroidism on the patients' clinical symptoms and/or family history. The Tribunal accepted this evidence.

127. Dr AC then went on to address the general arguments put forward by Dr Tudor, primarily within his Rule 4 and Rule 7 responses. Dr Tudor appeared to express contradictory approaches to the diagnosis and treatment of hypothyroidism. On some occasions, he seemed to concede that blood tests alone were required. On other occasions, Dr Tudor at least implied that diagnosis could be supported without appropriate blood results, but on history and/or symptoms. In any event, Dr Tudor appeared to argue that the reference ranges for TSH levels adopted in the UK were not appropriate. Even on this issue, there seemed to be some inconsistency of approach.

128. On the appropriate approach to diagnosing hypothyroidism, the Tribunal agreed with Dr AC. Diagnosis based on family history and/or clinical symptoms was not appropriate in the sense that it ran contrary to the clear guidance from the RCP. In other words, the only appropriate basis for diagnosis was blood results, and specifically raised TSH levels outside of the normal range.

129. In terms of the appropriate reference range for TSH, Dr AC confirmed that it should be between 0.27 to 4.2 micro units/litre (mu/l). The Tribunal accepted that this was the appropriate reference range, derived as it had been from large scale population studies. The Tribunal accepted that there was some academic controversy in the medical profession concerning this reference range. The Tribunal spent some time looking at this issue, but concluded that the extent of the disagreement in the UK would not have made a significant difference to the findings in relation to any of the patients in this Allegation. Dr AC stated that hypothyroidism would not usually be diagnosed unless the TSH levels were well above the normal range.

130. Dr AC said that 'T4' referred to free thyroxine levels which had a reference range of between 12 and 22 pmol/l. 'T3' refers to a form of thyroxine which has been partly produced by the thyroid gland and has then metabolised in the body. He said if 'T3' levels dropped and 'T4' levels remained within the normal range, that may be an indication of an acute problem with the thyroid gland. He said that it was an early indicator of a thyroid condition but was of limited general value and that NHS laboratories would not routinely report on T3 unless there was a suspicion of an acute thyroid condition.

131. Dr AC said that to treat hypothyroidism, both the TSH and T4 levels would need to be out of the normal range, suggestive of primary hypothyroidism with the TSH high and the T4 level low. The patient would also need to be suffering some of the relevant symptoms.

132. Dr AC said that if the blood results were just outside the normal range, but suggestive of primary hypothyroidism, a doctor might discuss this with the patient and have a period of observation which would involve giving them advice to revert back to the doctor, if the symptoms got worse, to undertake a further thyroid function test. He said, in some cases, if the patient did have an underactive thyroid, it might correct itself.

133. Dr AC was asked how far outside the normal range would the TSH have to be before a doctor would start actively prescribing treatment. He said that it was not the extent to which the TSH was outside the normal range for example 8mu/l, rather it was the presence of thyroid antibodies which was really important. He said if there were thyroid antibodies, the patient was going to have persistent thyroid disease. If the figures were just a few points outside the normal range the treatment would not necessarily start straight away. He said that it was rare for anyone to become unwell if monitored without starting treatment.

134. Dr AC said that Hashimoto's disease (a type of subclinical hypothyroidism) was an autoimmune disease version of the disease and one in which the thyroid antibodies are detected in the blood. It is a condition where the body develops antibodies to the thyroid and the thyroid is gradually destroyed by the action of those antibodies. He said that in cases of subclinical hypothyroidism, where the TSH level may be raised only marginally, but there is an indication of a thyroid problem, a result of the hypothalamus telling the thyroid to make more thyroxine, it may be considered as potentially an early stage of primary hypothyroidism. Dr AC explained that the thyroid would be failing, under stress, but that it would not have yet reached the point where it could not make enough thyroxine to stay within the normal range.

135. Additionally, this also occurred in acute thyroid conditions such as thyroiditis where the thyroid is under stress and it is not working quite as effectively as it should be. Dr AC said that this is why the RCP suggests observation in this instance, though it does allow for treatment of a patient where they are suffering significant conditions on the understanding that their thyroid disease is not fully diagnosed. He said the guidance recommended starting treatment at a low dose of levothyroxine and with a close review of the patient. He said generally the advice was to observe these patients, give them safety netting and advice on what conditions and symptoms might develop as the condition progresses. They should undertake a follow up blood test within a few months to determine if they have developed hypothyroidism or an acute thyroid condition, in which case the blood tests will tend to come back abnormal.

136. Dr AC told the Tribunal that levothyroxine was a cheap version of synthetic thyroxine and that it was a common treatment for hypothyroidism. He said that once hypothyroidism was diagnosed, the guidance recommended starting treatment with levothyroxine at a low dose.

137. Dr AC stated that over treatment of levothyroxine could lead to hyperthyroidism, the side effects of which could include an increase in the heart rate and the development of heart arrhythmias, particularly atrial fibrillation. He said this would require a reduction in treatment, or if severe, treatment with a beta blocker. The Tribunal accepted and relied upon the expert evidence of Dr AC in relation to all of these issues.

Rheumatoid Arthritis

147. The NICE guidance states that:

"Rheumatoid arthritis: Summary

- *Rheumatoid arthritis (RA) is a chronic systemic inflammatory disease.*
  - *RA typically presents as inflammatory arthritis affecting the small joints of the hands and the feet (usually both sides equally and symmetrically) although any synovial joint can be involved.*
  - *As RA progresses, any system of the body may be affected, leading to an increased risk of premature death.*
  - *RA is associated with a number of complications and comorbidities, such as an increased risk of cardiovascular disease, osteoporosis, anaemia, and infection.*

  …

- *Clinical features of synovitis include pain, swelling, heat and stiffness in affected joints.*

  ….

- *Management of RA should be managed under specialist care, where a treat to target strategy is used - the aim is to achieve a target of remission or low disease activity if remission cannot be achieved.*

- *Specialists will usually offer a conventional disease modifying anti-rheumatic drug (cDMARD) as monotherapy - for example, oral methotrexate, leflunomide, or sulfasalazine. The dose is increased depending on tolerance*.

138. In the NHS Greater Manchester Medicines Management Group 'Shared Care Protocol', it stated:

"2. Licensed Indications

Oral methotrexate is licensed to treat adults with rheumatoid arthritis and is also widely used to treat other inflammatory arthritis and connective tissue diseases including adults with juvenile inflammatory arthritis.

3. Criteria for shared care

Prescribing responsibility will only be transferred when

- *Treatment is for a specified indication.*
- *Depending upon local commissioning arrangements there are two models for DMARD shared care across the conurbation:*
    - *Model a) Specialist prescribes and monitors until patient on stable dose (usually 3 months) then prescription/ monitoring shifts to primary care with support/ guidance from secondary care.*
    - *Model b) Primary care prescribes and monitors from the beginning with support/ guidance from secondary care.*

- *The GP has agreed in writing in each individual case that shared care is appropriate.*
- *The patient's general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements"*
  ….

8. Dosage regimen for continuing care

Route of administration: Oral

Preparations available: Methotrexate 2.5mg tablets

CSM warning with methotrexate that doses are weekly and attention should be paid to the strength of methotrexate tablets prescribed and the frequency of dosing. 2.5mg tablets are recommended in Greater Manchester however, patients should be made aware of other strengths and to question possible discrepancies.

Please prescribe:

7.5-25mg ONCE weekly according to hospital instructions (the initial dose may be 5-15mg once weekly, increasing by 2.5mg-5mg every 2-6 weeks until the disease is stabilized) Only prescribe 2.5mg tablets to avoid dosing errors."

149. In respect of methotrexate the British National Formulary ('BNF'), sets out:

"Methotrexate

DRUG ACTION Methotrexate inhibits the enzyme dihydrofolate reductase, essential for the synthesis of purines and pyrimidines.

- *Indication and Dose*

…

Moderate to severe active rheumatoid arthritis

- *BY MOUTH*

- *Adult: 75mg once weekly, adjusted according to response; maximum 20mg per week*

  …

SIDE EFFECTS
Common or very common

- *With intra-arterial and intravenous use: Abdominal distress; fever; headache; leucpenia; nausea; oral disorders; vomiting*

  ….

- *With oral use: Anaemia; appetite decreased; diarrhoea; drowsiness; fatigue; fever; gastrointestinal discomfort; headache; increased risk of infection; leucpenia; nausea; oral disorders; respiratory disorders; skin reactions; throat ulcer; thrombocytopenia; vomiting…*

SIDE EFFECTS, FURTHER INFORMATION Give folic acid to reduce side-effects. Folic acid decreases mucosal and gastrointestinal side-effects of methotrexate and may prevent hepatotoxicity; there is no evidence of a reduction in haematological side-effects…"

- *MONITORING REQUIREMENTS*

In view of reports of blood dyscrasias (including fatalities) and liver cirrhosis with low-dose methotrexate patients should:

  - *Have full blood count and renal and liver function tests repeated every 1-2 weeks until therapy stabilised, thereafter patients should be monitored every 2-3 months*

- *Be advised to report all symptoms and signs of suggestive of infection, especially sore throat"*

139. In his oral evidence, Dr AC told the Tribunal that rheumatoid arthritis was an acute autoimmune disease where the body produces antibodies within multiple joints. He said that someone with this condition would initially be fine or have minimal problems with their joints and then suddenly a large number of joints would be affected at virtually the same time. He said the joints would become painful, swollen and hot and then the function of those joints would become reduced. He said that if this persisted the inflammation of the lining of the joint would begin to destroy other structures in and around the joints, and the patient could become permanently disabled.

140. Dr AC told the Tribunal that the course of rheumatoid disease can be variable and that some people may sometimes have initial pain in their joints which then settles down and then a similar episode will occur some point later. He said that if the pattern is identified quickly, and if appropriate, the patient would be started on a drug like methotrexate. Dr AC said that methotrexate was a disease modifying drug in the sense that it would reduce inflammation and prevent these long term changes to the joints and to the structures around the joints, reducing the likelihood of disability.

141. Dr AC identified three things which should be undertaken in diagnosing patients with rheumatoid arthritis. Firstly, clinical assessments as they were very important in identifying inflammation in the joint. Secondly, a range of blood tests to identify inflammatory markers in the body. Thirdly, following the blood tests, it would then be appropriate for a GP to make an urgent referral for a patient to see a rheumatologist or a qualified GP with a special interest in rheumatoid arthritis for their opinion on diagnosis and whether to prescribe methotrexate or a similar treatment.

142. Dr AC also told the Tribunal that because of the significant side effects when methotrexate was prescribed, there should be counselling of the patient, during which they should be made aware of these side effects, the dose they should take and how often they should take it. There should be a monitoring plan put in place with blood tests taken every 1-2 weeks initially, until stable.

143. Dr AC made the observation that methotrexate was banned in some countries and restricted in certain states in America because it can cause deformity to a foetus and therefore be used to induce abortion. He stressed that caution needed to be taken when prescribing it to women of childbearing age.

144. Dr AC referred the Tribunal to a leaflet 'NHS: National Patient Safety Agency – methotrexate treatment', which should be given to patients as part of their counselling, which stated:

"Low dose methotrexate (25mg or less once a week)

What it is

Methotrexate was first used, in high doses, to treat cancer but experience over thirty years has shown that methotrexate at much lower doses is helpful in the treatment of a number of joint, skin and bowel conditions
….

What methotrexate can do

Methotrexate acts by slowing the production of new cells by the body's immune system. This helps to reduce the inflammation that causes swelling and stiffness of joints…
….

*…**You must not take** methotrexate if you might be pregnant or are wishing to start a family.*
…

Your dose

*A typical dose will range from 7.5mg to 25mg **once a week**. Methotrexate is **never** taken every day….*
…

Why you need regular blood tests

When you first start treatment, blood tests will usually be taken every week or at least once a fortnight. Once the dose is stable, and the blood tests are satisfactory, the frequency of your monitoring will be reduced. Regular blood tests will help your doctor, nurse or pharmacist check how well your body is coping with the methotrexate and will help to decide whether you can continue on the treatment.

…

Feeling sick, upset stomach or diarrhoea

When you first start treatment you may feel unwell. This normally settles but may persist. Speak to your doctor or nurse as something can be done to help. These symptoms can be helped in one of three ways:

- *you may be advised to increase the amount of the folic acid supplement you take;*

- *you may be advised to take another tablet that reduces the feeling of sickness. These tablets are called antiemetics;*

- *the doctor may wish to change your treatment to methotrexate by injection once a week.*

If you vomit within a few hours of taking methotrexate ***do not take another dose****. Make a note that you have been unable to take your tablet and tell your doctor or nurse if this happens again the following week.*

Effects on your bone marrow or liver

Your blood tests will help to monitor these. Symptoms that may show problems with the bone marrow or liver include regularly catching infections, bruising or bleeding easily. Your doctor or nurse monitoring your treatment will contact you if there are any problems with your blood test results. Occasionally changes in your blood may mean you have to stop your methotrexate.

Mouth ulcers, sore throat or sore mouth

If you experience mouth ulcers, or a sore throat or mouth, speak to your doctor, nurse or pharmacist. It may be necessary for you to have a blood test to check how your body is coping. In many cases, if your blood tests are normal, you may be given some medication to treat these problems.

Infections

Methotrexate may reduce your ability to fight infections and this can be a problem in some individuals who may be more vulnerable to infections.

It is important to get prompt advice if you think you have an infection (for example, a wound that fails to heal promptly, pain or burning when passing water, or a chest infection).

Rashes – new rash or severe itching anywhere on the body

If you get a new rash or severe itching seek advice from your doctor, nurse or pharmacist.

Thinning of the hair

This can happen, although it is uncommon and, if it does happen it is usually slight. Hair growth usually returns to normal on stopping treatment. If you

feel this becomes more than a very slight hair loss you should discuss it with your doctor.

Other problems may be experienced. Report these to your doctor or nurse if the problems continue or if they occur after every dose.

Side effects/problems that mean I need to stop treatment immediately and get urgent medical advice Shortness of breath (breathlessness)

Methotrexate can very occasionally cause inflammation of the lungs. The breathlessness caused by methotrexate can come on gradually or over a few days. You may also have a dry cough. If you feel breathless when resting and you don't have a heavy cold (runny nose and temperature) you should ***stop your methotrexate*** *and* ***contact your doctor or nurse.*** *It is important that the doctor examines you as very occasionally methotrexate can cause severe inflammation of the lungs.*

If the whites of your eyes become yellow or you develop severe itching of the skin *Stop treatment and seek advice from your doctor or nurse, as these are sometimes signs of liver problems."*

145. The Tribunal accepted the unchallenged evidence of Dr AC that the appropriate pathway to a diagnosis of rheumatoid arthritis or psoriatic arthritis was, following assessment by the GP, blood tests, and then, if indicated, urgent referral to a specialist in rheumatology. It would then be for that specialist to diagnose the patient and, if clinically indicated, decide whether methotrexate should be prescribed.

146. The Tribunal also accepted that appropriate counselling ought to be given to the patient prior to prescribing methotrexate, which should include providing a patient safety leaflet (of the type mentioned above) and setting out the dosage to take, when to take it, and what the side effects may be. Folic acid is always prescribed with methotrexate to combat side effects. It would also be appropriate to carry out regular review, and to have a care plan which includes regular blood tests approximately every fortnight for up to three months until stable, and only reduced at the discretion of the specialist.

147. The Tribunal was also satisfied that another important factor when prescribing such a toxic drug to a patient would be for the prescriber of methotrexate to communicate this information with the patient's NHS GP. Further, it would be appropriate for the prescriber of methotrexate to make a very careful and clear record of diagnosis and treatment. For instance, notes of the symptoms relied upon when making a diagnosis; blood test results; and of any referral to a specialist; any counselling given and consent obtained; and any plan for monitoring the patient's reaction to methotrexate.

Patient A

148. At the relevant time, Patient A was a 70 year old woman with a complex past medical history of fibromyalgia, arthritis (possibly Sjogren's syndrome) and asthma. Patient A had a complex medication history having been prescribed high doses of morphine and diazepam by various doctors, including Dr Tudor. She had previously seen rheumatologists for her joint pains but had not been prescribed methotrexate in the past.

149. On 19 July 2017 Dr Tudor saw Patient A as a new patient. She described a complex past medical history including general malaise and tiredness. Dr Tudor arranged for a blood sample to be taken. On 2 August 2017 Dr Tudor saw Patient A and referred to blood tests done by the NHS surgery which were stated to include a TSH 2.1 (0.30-6.00). Dr Tudor also referred to blood tests undertaken by him at the previous appointment which showed:

TSH 1.62 mu/l	(Range 0.27-4.2)
Total Thyroxine 79 pmol/l	(Range 59-154)
Free Thyroxine T4 13.7pmol	(Range 12.0-22.0)

Thyroid antibodies were normal.

150. On the basis of these blood tests Dr Tudor started levothyroxine 25mcg once daily. On 16 August 2017 Dr Tudor saw Patient A and increased her levothyroxine to 100mcg daily. There is no indication that any blood test results informed this management. Subsequently Dr Tudor saw Patient A repeatedly and continued to manage her supposed hypothyroidism along with various other conditions. Of note is a blood test undertaken on 7 February 2018 showing that had a free thyroxine level of 30.5 pmol/l, showing that she was markedly overtreated with levothyroxine, which led to Dr Tudor reducing dose of levothyroxine from 150mcg daily to 125mcg daily.

151. In his Rule 4 response to this aspect of the Allegation, Dr Tudor stated:

"I wish to clarify the reason I prescribe Levothyroxine.

I am interested in auto immune disorders which are often undiagnosed and treated and if not diagnosed and treated result in years of morbidity. Auto immune disorders affect all systems especially the thyroid gland the stomach the small bowel and joints. Symptoms include tiredness, slow thoughts, feeling cold, hair loss, dry skin, epigastric pain, heartburn, abdominal pain, bloating, wind, pelvic pain and joint pain due to thyroiditis gastritis intestinal enteropathy and inflammatory arthritis.

The symptoms can be vague and are often attributed to depression irritable bowel chronic fatigue and fibromyalgia.

The diagnosis of an auto immune disorder depends on taking a detailed history including family history as the disorder is familial a full examination and comprehensive blood tests.

In relation to tiredness slow thoughts feeling cold and hair loss these symptoms are due to subclinical hypothyroidism. In subclinical hypothyroidism blood tests may be abnormal but within range and this is a causes confusion.

Treatment of subclinical hypothyroidism is with thyroxine - in fact in my experience a small dose of Levothyroxine stops these symptoms.

Once started on treatment the patient is monitored - blood tests are performed every 3 months so that there is no question of over-treatment. Irrespective of Levothyroxine the thyroiditis continues for years until the thyroid gland itself fails completely.

NHS GP's are restricted to TSH tests - if the level is normal then it is assumed that the patient is normal but this is not the case with patients suffering from subclinical hypothyroidism.

The difficulties arise when a patient asks a NHS GP for a prescription for Levothyroxine which without a raised TSH they are unable to provide."

152. In his Rule 7 response, Dr Tudor stated that he first saw Patient A at his clinic on 19 July 2017 and that she presented with multiple problems and that she had been told by her GP that she was suffering from fibromyalgia. He said her blood tests revealed TSH 2.1 (T4 and T3 levels were not tested) and TPO (thyroid peroxidase) antibodies.

153. Dr Tudor stated that the TMM blood test revealed TSH of 1.62, T4 of 13.7 and T3 of 4.3. He also stated that the presence of TPO antibodies indicated active Hashimoto's thyroiditis which always caused hypothyroidism. He said that he felt that it was not unreasonable to put Patient A on levothyroxine and that within a few days she felt considerably better.

154. Dr Tudor also stated that Patient A continued to take levothyroxine albeit he adjusted the dosage periodically depending on her symptoms and thyroid function tests. He said that Patient A experienced progressive severe synovial joint pain; stiffness typical of rheumatoid arthritis /osteoporosis; neck and back pain; bilateral knee pain with both knees tender and swollen, and pains in her hands and feet.

155. Dr Tudor said that the diagnosis of hypothyroidism was never in doubt because Patient A had Hashimoto's thyroiditis as evidenced by the blood tests. Dr Tudor maintained that treating Patient A with levothyroxine, methotrexate and prednisolone was reasonable and necessary for her own benefit.

<u>Paragraph 1 of the Allegation</u>

On 2 August 2017 you consulted with Patient A and you failed to make an appropriate diagnosis in that you diagnosed hypothyroid-ism despite Patient A's blood results indicating a normal thyroid function. **Found proved**

156. In his expert report, Dr AC stated when Dr Tudor saw Patient A on 19 July 2017, he took a history which included some clinical features of possible hypothyroidism, and that this was an appropriate working diagnosis justifying further investigations. Dr Tudor undertook blood tests which showed normal thyroid function. Thyroid antibodies were stated to be normal. However, by implication Dr Tudor made a diagnosis of hypothyroidism and started treatment with levothyroxine 25mcg daily, which could therefore not be justified.

157. In his Rule 7 response Dr Tudor stated that the presence of TPO antibodies indicated active Hashimoto's thyroiditis which always causes hypothyroidism. He went on to explain that even though TSH levels were not raised, T4 and T3 levels were low. He felt it was not unreasonable to put her on levothyroxine. He stated that she felt better a few days later. Dr Tudor went on to state that Patient A went on to take levothyroxine, the dose of which was adjusted periodically depending on symptoms and the results of thyroid function tests. The Tribunal had regard to Dr Tudor's responses in this document. However, in the case of Patient A, he appeared to disregard the normal blood results, and founded his diagnosis on clinical signs alone. This was clearly contrary to the relevant guidance as set out above.

158. The Tribunal found it difficult to ascertain Dr Tudor's rationale for the diagnosis of hypothyroidism, though it noted that within the medical record, did not expressly record such a diagnosis. However, Dr AC said that such a diagnosis could be inferred from the issuing of levothyroxine, a deduction with which the Tribunal agreed. Paradoxically, in his Rule 7 response, Dr Tudor suggested that he had diagnosed Hashimoto's thyroiditis, a form of hypothyroidism.

159. Whatever form of hypothyroidism Dr Tudor diagnosed, the blood tests which were available to him demonstrated that the TSH and T4 levels were within the normal range and were not indicative of hypothyroidism. As far as the Tribunal was concerned, Dr Tudor's rationale for a diagnosis of hypothyroidism was without justification, inconsistent and confused.

160. The Tribunal noted that the guidance could not be any clearer, that a diagnosis of hypothyroidism could not be justified without the TSH and T4 being outside the normal range. This was not the case here.

161. The Tribunal therefore found paragraph 1 of the Allegation proved.

Paragraph 2(a) of the Allegation

On one or more of the dates set out in Schedule 1 you failed to:

(a) prescribe appropriately in that you prescribed Levothyroxine for Patient A when it was not clinically indicated; **Found Proved**

162. The Tribunal determined that if Dr Tudor failed to make an appropriate diagnosis in that he diagnosed hypothyroidism despite Patient A's blood results indicating a normal thyroid function, any prescription of levothyroxine thereafter to treat hypothyroidism would not be clinically indicated. Dr Tudor first prescribed levothyroxine to Patient A on 2 August 2017.

163. There were no blood results within the medical records demonstrating TSH and T4 levels outside the normal range to justify any subsequent treatment with levothyroxine during the period as set out in Schedule 1. There was evidence within the medical records that Dr Tudor did in fact increase the dose on 16 August from 50mg to 100mg daily. This was not indicated.

164. The Tribunal found that Dr Tudor did therefore fail to prescribe appropriately in that he prescribed levothyroxine for Patient A when it was not clinically indicated on one or more occasions in Schedule 1.

165. The Tribunal therefore found paragraph 2(a) of the Allegation proved.

Paragraph 2(b)-(c) of the Allegation

On one or more of the dates set out in Schedule 1 you failed to:

(b) obtain informed consent from Patient A in that you did not advise Patient A:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; Found not proved

(ii) of the potential for Patient A to experience serious side effects; Found not proved

(c) make a record of having undertaken the actions referred to at paragraph 2b. Found proved

166. The Tribunal accepted and relied upon the evidence of Dr AC in that there should have been a discussion with Patient A about Dr Tudor's decision to diagnose hypothyroidism contrary to appropriate practice, to prescribe levothyroxine outside of relevant guidance, and about the side effects of levothyroxine and any symptoms she should look out for.

167. The Tribunal found that there was a significant risk of over treatment. Further, that once Patient A was diagnosed with hypothyroidism, treatment with levothyroxine would be likely to continue for the rest of her life. There was no record in the medical notes of Patient A having been told this, or of explicit informed consent having been obtained. Given the extent to which Dr Tudor was acting outside of normal guidance, the Tribunal was satisfied that explicit informed consent was necessary.

168. It was the GMC's case that there was sufficient evidence that such a discussion had not taken place with the patient. It relied on the absence of any record in the medical notes; that there was a positive obligation to make notes about the treatment; and that in such a case involving treatment outside of normal guidance, that the need to make a note was even more compelling. Further, Dr Tudor made no comment in his Rule 7 response as to informed consent having been obtained.

169. The Tribunal was of the view that Dr Tudor had a positive obligation to maintain patient records as part of GMP, especially when he was prescribing outside of the guidance. However, it was the GMC's own case that Dr Tudor was often guilty of poor record keeping. The Tribunal therefore found that the simple absence of an appropriate note was not sufficient proof that a conversation regarding informed consent had not taken place. The Tribunal reminded itself that Dr Tudor did not have to prove anything, and felt that in respect of this aspect of the case, that there was a danger of reversing the burden of proof. The Tribunal noted that there was no direct evidence from either participants in these conversations. The Tribunal determined that the GMC had not proven its case on the balance of probabilities.

170. The Tribunal therefore found paragraph 2(b)(i) and (ii) not proved, and paragraph 2(c) of the Allegation proved in that, based on the observations above, that the notes made by Dr Tudor on the various occasions set out in Schedule 1, were absent of any note of the appropriate discussions, and were inadequate.

The prescribing of Methotrexate to Patient A

171. On 18 May 2019 Dr Tudor spoke to the husband of Patient A on the telephone and took a history of improved joint pains and her general condition on steroids, which had been prescribed for a possible exacerbation of her asthma. Dr Tudor advised regular oral steroids and initiated methotrexate 12.5 mg once a week. There was no indication that a rheumatology opinion had been obtained to support this decision, nor was Patient A prescribed folic acid. A blood test was undertaken the results of which showed no significant abnormality.

172. On 6 June 2019 Dr Tudor saw Patient A and described improvements in her joint pain and continued to prescribed methotrexate. There were no further blood tests carried out for monitoring the use of methotrexate in the coming months, de-spite Dr Tudor seeing her several times. Then on 10 December 2019 Dr Tudor saw her and considered her to have a pale appearance and a petechial rash so that he immediately stopped methotrexate, concerned that this was causing a severe side effect. A blood test was undertaken which showed no significant abnormality.

173. In March 2020, a private rheumatology referral was made. It was not entirely clear who made the referral. Doing the best it could with the evidence, the Tribunal found that Dr Tudor had played some role in making this referral. The specialist wrote a letter to Dr Tudor

on 27 May 2020 in which he did advise the introduction of methotrexate and gave advice on monitoring by Dr Tudor as per the local guidelines.

174. In his Rule 7 response, Dr Tudor said that he referred Patient A to a consultant orthopaedic surgeon who arranged for Patient A to have facet injections. He stated that the knee pain was so bad that Patient A was prescribed morphine sulphate to use as required. In addition, she was prescribed prednisolone to help with the pain and stiffness. Dr Tudor stated that because of the complications of prednisolone and as a steroid sparing measure, he gradually titrated the dose of prednisolone down whilst at the same time introducing methotrexate at 12.5mg per week.

175. Dr Tudor stated that in respect of the methotrexate, he took the following steps:

1. Made sure that Patient A was monitored before and during her treatment.
2. Informed Patient A's GP - Dr Tudor stated that Patient A's medical records show that her GP was sent details of each consultation whilst she was under his care.
3. Dr Tudor stated that he counselled Patient A on the use of methotrexate beforehand.

176. Dr Tudor stated that he referred Patient A to a consultant rheumatologist who agreed with his own diagnosis of rheumatoid arthritis /osteoporosis and who advised to continue to treat Patient A with methotrexate and prednisolone.

<u>Paragraphs 3(a)-(c) of the Allegation</u>

On one or more of the dates set out in Schedule 2 you failed to:

(a) prescribe appropriately in that you prescribed Methotrexate for Patient A when:

(i) it was not appropriate for you to do so without input from an appropriately qualified specialist; **Found proved**

(ii) Patient A had not been diagnosed with:

(1) rheumatoid arthritis; **Found proved**

(2) psoriatic arthritis; **Found proved**

(iii) you prescribed a higher dose than advised in the British National Formulary ('BNF') guidance; **Found not proved**

(iv) you did not:

(1) also prescribe folic acid to limit the side effects of Methotrexate; **Found proved**

(2) arrange for Patient A to be monitored before initiation of Methotrexate; **Found proved**

(3) put a plan in place for Patient A to be monitored on a weekly/fortnightly basis after initiation of Methotrexate; **Found proved**

(4) advise Patient A's NHS General Practitioner ('GP') of the prescription; **Found not proved**

(b) obtain informed consent from Patient A in that you did not adequately counsel Patient A on the use of Methotrexate; **Found proved**

(c) make a record of having undertaken the action referred to at paragraph 3b. **Found proved**

177. The Tribunal accepted Dr AC's opinion that rheumatoid arthritis would have been an appropriate differential diagnosis to have made in the circumstances. However, there was no express diagnosis in the medical notes. In respect of paragraph 3(a)(i), the Tribunal was satisfied that Dr Tudor had failed to refer patient A to an appropriately qualified specialist prior to the prescribing of methotrexate, as set out in the guidance. Neither were there any blood results to justify the prescription. Dr Tudor had therefore failed to appropriately prescribe methotrexate to Patient A.

178. Dr Tudor recorded that he prescribed methotrexate to Patient A and that there had been an improvement in her condition once prescribed, though he gave no further detail. Dr Tudor also recorded said in his Rule 7 response that Patient A had seen a rheumatologist, but this was clearly a reference to the referral in March 2020, which was 10 months after the original prescription of methotrexate.

179. There is no evidence within the medical notes that Dr Tudor made a specific diagnosis of rheumatoid arthritis. The Tribunal considered that it could have been Dr Tudor's working hypothesis, but in the absence of a specific note of recorded symptoms, referral to a specialist or blood test results, it was not clear.

180. The Tribunal determined that Dr Tudor did not therefore diagnose Patient A with rheumatoid arthritis or psoriatic arthritis.

181. In respect of paragraph 3(a)(iii), the Tribunal found that the BNF guidance states that for an initiating prescription of methotrexate, the dose should be between 7.5mgs with a maximum dose of 20mgs weekly. The Tribunal accepted that had the prescription been properly indicated, then the dose prescribed by Dr Tudor, namely 12.5 mgs weekly, was an

appropriate dose, albeit at the high end of the recommended range. Dr AC's opinion was that the initiating dose should be right at the lower end of the range indicated in the BNF guidance at 7.5mg and that there needed to be a special indication to raise the dosage above 7.5mgs. The BNF did not specify that an initiating dose must be at the lower end of that range. The Tribunal therefore determined that when considering the BNF in those terms, paragraph 3(a)(iii) was not made out.

182. In respect of paragraph 3(a)(iv)(1), the Tribunal considered that there was no evidence before it in the medical record to suggest that Dr Tudor prescribed folic acid to Patient A to limit the side effects of methotrexate. In addition, Dr Tudor made no reference to having prescribed folic acid in either his Rule 4 or Rule 7 response. The Tribunal considered that the guidance was quite explicit, in that folic acid should be prescribed together with methotrexate. It therefore determined that Dr Tudor had failed to prescribe folic acid to limit the side effects of methotrexate, when it was appropriate to do so.

183. In respect of paragraph 3(a)(iv)(2), the Tribunal was satisfied that the monitoring of the patient was an important part of the regimen before a prescription of methotrexate is issued to the patient, by way of blood testing. There was no evidence before the Tribunal that this occurred in this case and Patient A was prescribed methotrexate without the pre-requisite blood tests. The Tribunal determined that Dr Tudor had therefore failed to arrange for Patient A to be monitored before initiation of methotrexate, when it was appropriate to do so.

184. In respect of paragraph 3(a)(iv)(3), the Tribunal noted that on 18 May 2019 the medical record was silent as to any care plan, or monitoring, post initiation of methotrexate. Dr Tudor did record blood tests on 21 May 2019, though it was not clear what those blood tests were for, and in any event, the Tribunal was not satisfied that they constituted a satisfactory plan of monitoring.

185. The Tribunal noted that a second blood test was taken about two and a half months after initiation on methotrexate, when they should have been undertaken fortnightly. There was no reference to a referral to a specialist until almost a year after Patient A was started on methotrexate.

186. The Tribunal was satisfied that Dr Tudor seeing Patient A four times in two and a half months was not sufficient to constitute an appropriate plan for monitoring Patient A and did not meet the requirement for blood tests every week/fortnight after initiation of methotrexate, as set out in the charge. It considered Dr Tudor's care to be very limited, ad hoc, and inappropriate by reference to the applicable guidance.

187. In respect of paragraph 3(a)(iv)(4), it was apparent from the medical records that Dr Tudor had notified Patient A's GP on about 31 July 2019 and 28 August 2019, to name but two occasions. The Tribunal was of the view that given the toxicity of methotrexate and how significant a prescription that was, it would have been better if any other medical professionals involved in the care of Patient A would have been notified on or very soon after

18 May 2019. However, Dr AC has clearly overlooked this part of Patient A's notes, and was clearly wrong. This part of the allegation was not proven.

188. Paragraph 3(b) alleges that Dr Tudor failed to obtain informed consent from Patient A in that he did not adequately counsel Patient A on the use of methotrexate. The Tribunal noted that Dr Tudor did not even speak to Patient A when he prescribed methotrexate on 18 May 2019. The medical record demonstrated that the initial prescription came about from Dr Tudor having had a telephone call with Patient A's husband.

189. The Tribunal considered that given the prescription was for methotrexate, Dr Tudor should have consulted directly with the patient. He did not actually see Patient A until 6 June 2019, some three weeks after the prescription. Dr AC's evidence was that informed consent and adequate counselling should have occurred before initiating a patient on methotrexate. The Tribunal determined that, on the balance of probabilities, as Dr Tudor had not even spoken to Patient A, he had failed to obtain explicit informed consent or provide adequate counselling before initiating Patient A on methotrexate on 18 May 2019.

190. In respect of paragraph 3(c), the Tribunal was satisfied that Dr Tudor failed to make a record of having undertaken the action referred to at paragraph 3(b). The Tribunal again noted that he did not even speak to Patient A. Further, there was no record of a discussion having occurred at any time.

191. In light of the unusual steps taken by Dr Tudor in prescribing methotrexate to Patient A on the strength of a telephone call with her husband, the Tribunal would have expected to have seen a note in the medical record on 6 June 2019 detailing the specific counselling and obtaining of consent. However, there was nothing to that effect.

192. The Tribunal therefore found paragraph 3(c) proven.

<u>Patient B</u>

193. Patient B was a 47 year old woman with no significant past medical history. On 7 November 2017 Patient B had blood tests taken by her NHS surgery. The results included a TSH of 1.9mu/l, which was normal, a normal full blood count, which did not show any features of an iron deficiency anaemia, and a ferritin level of 19ug/l which was normal.

194. On 1 December 2017 Dr Tudor noted that Patient B's Vitamin B12 level was 'at the lower end of normal' and other blood tests were normal. On 6 December 2017 Dr Tudor arranged for a blood test to be taken from Patient B. The results were:

TSH 1.20 mu/l	(Range 0.27-4.20)
Free Thyroxine (T4) 10.4 pmol/l	(Range 12.0 – 22.0)
Free T3 3.6 pmol/l	(Range 3.10-6.80)

Thyroid antibodies were normal. These results, showing a normal TSH with a slightly low T4 level were not consistent with a diagnosis of subclinical hypothyroidism.

195. On 12 December 2017 Dr Tudor saw Patient B and stated that Patient B's ferritin was 19 ug/l (Range stated as 10-291, ug/l) and Vitamin D was 50 nmol/l (range stated as 50-150 nmol/l). Dr Tudor also stated that thyroid function tests showed low thyroid function consistent with sub clinical hypothyroidism. Dr Tudor prescribed levothyroxine 25mcg once daily x 60. Dr Tudor proceeded to give Patient B a Vitamin B12 injection and an intramuscular injection of Cosmofer 50mg/ml x 2mls, an iron injection into the right buttock. Dr Tudor recorded the batch number and expiry date of both injections.

196. On 19 January 2018 Dr Tudor saw Patient B and stated that she was 'brighter during the day.' Dr Tudor undertook blood tests for thyroid function and advised that Patient B increase her levothyroxine to 50mcg daily. Dr Tudor advised review in 6 weeks' time. It was noted that Patient B's 'Right buttock [was] still tender,' presumably from her iron injection.

197. On 25 April 2018 Dr Tudor saw Patient B and took a history of anxiety, poor sleeping and feeling 'jittery.' The blood tests undertaken by Dr Tudor showed:

TSH 0.22 mu/l	(Range 0.27-4.20)
Free Thyroxine (T4) 17.5 pmol/l	(Range 12.0 – 22.0)
Free T3 4.90 pmol/l	(Range 3.10-6.80)

198. On 1 May 2018 Dr Tudor saw Patient A and referred to blood test results that showed Patient B's TSH was slightly low, and therefore overtreated with levothyroxine, and increased her levothyroxine dose to 100mcg once daily.

199. In his Rule 7 response, Dr Tudor stated that Patient B presented with a multitude of symptoms, in particular, tiredness all the time, dry skin feeling cold and weight gain. He said that the examination was uninformative. He stated that Patient B's blood tests were normal except that B12 and ferritin levels were very low but full blood count was normal. He said that low B12 levels were due to absence of 'intrinsic factor'.

200. Dr Tudor also stated that Patient B's T4 and T3 levels were very low and were consistent with hypothyroidism, with possible central hypothyroidism as the TSH level was normal. He said that Patient B's thyroid antibodies were raised which suggested that she had active Hashimoto's thyroiditis, with thyroiditis always resulting in hypothyroidism. He said that a lack of intrinsic factor and Hashimoto's thyroiditis were auto immune conditions.

201. Dr Tudor went on to explain that he was in no doubt as to the diagnosis of B12 deficiency, iron deficiency and hypothyroidism. He said that he prescribed an injectable iron preparation called Cosmofer as Patient B was unable to tolerate oral iron. He also prescribed levothyroxine at 25mcg once daily.

202. Dr Tudor stated that he had suggested she be reviewed 4 weeks later, at which point she reported that her symptoms were improving. Subsequent to this, he increased the dosage of levothyroxine to 50mcg once daily, then to 75 mcg once daily, and then to 100mcg once daily. He said that he increased the dosage in line with Patient B's symptoms, signs and blood test results.

203. Dr Tudor said that in August 2018 Patient B's level were TSH 0.243, T4 18.6, T3 4.64, iron 21.49, TIBC 57.39, Transferrin saturation 37.45, and Ferritin 58.1. He said that the last time he saw Patient B she was feeling much better overall.

Paragraphs 4(a)-(b), and 5 of the Allegation

On 12 December 2017 you consulted with Patient B and you failed to:

(a) make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient B's blood results not clearly indicating hypothyroidism; Found proved

(b) prescribe appropriately in that you prescribed:

(i) Levothyroxine 25mcg when this was not clinically indicated; Found proved

(ii) a Cosmofer injection when Patient B did not have iron deficiency anaemia. Found proved

5. On 1 May 2018 you inappropriately prescribed for Patient B in that you increased Patient B's prescription of levothyroxine to 100mcg daily when this was not clinically indicated. Found proved

204. In relation to this part of the Allegation, the Tribunal accepted Dr AC's opinion. The diagnosis of hypothyroidism in the case of Patient B made on 12 December 2017, was based on her history of possible hypothyroidism taken on 29 November 2017 and blood tests results. This was not correct. Although they showed a slightly low T4, this was not a basis on which to diagnose hypothyroidism, whether subclinical or overt. The conventional definition of subclinical hypothyroidism refers to a raised TSH associated with a normal T4. A low T4 with a normal TSH is not clearly indicative of hypothyroidism. It would be warranted to repeat this test but not to diagnose and treat hypothyroidism on this basis. Dr Tudor's making a diagnosis of hypothyroidism for Patient B was not consistent with appropriate guidance and was not consistent with GMP. Dr Tudor provided treatment for Patient B which was not justified and from which she was at risk of side effects.

205. The Tribunal considered that within the medical record on 12 December 2017 Dr Tudor noted a diagnosis of sub-clinical hypothyroidism on the basis that he records the thyroid function tests demonstrated a low thyroid function. In his Rule 7 response, he

suggested possible central hypothyroidism and then active Hashimoto's thyroiditis. The Tribunal found it difficult to discern exactly what diagnosis Dr Tudor was making.

206. The Tribunal was satisfied that the TSH, T4 and T3 all appeared to be within the normal range. It did not therefore accept that there was any justification for any diagnosis of any kind of hypothyroidism, however Dr Tudor had arrived at that conclusion.

207. The Tribunal also determined that as Dr Tudor failed to make an appropriate diagnosis in that he diagnosed hypothyroidism despite Patient B's blood results not clearly indicating hypothyroidism, it followed that any prescription of levothyroxine to treat that hypothyroidism was not clinically indicated.

208. In respect of paragraph 4(b)(ii), as to whether Dr Tudor failed to prescribe appropriately in that he prescribed a Cosmofer injection when Patient B did not have iron deficiency anaemia, the Tribunal also agreed with Dr AC's unchallenged evidence. The diagnosis of iron deficiency in the case was based on Dr Tudor's consideration of NHS surgery blood tests from 12 December 2017 with a normal FBC and a ferritin result of 19, which was within the normal range. The Tribunal found that this, in itself, was not sufficient to make the diagnosis of an iron deficiency anaemia and, that it was inappropriate for Dr Tudor to determine that Patient B was iron deficient. Patient B was at risk of developing side effects from oral iron if prescribed for her condition, but these effects would have been unlikely to be serious. Dr Tudor's prescribing of injectable iron was exceptional and this placed her at more risk than would have usually been the case with an inappropriate diagnosis of iron deficiency anaemia.

209. The Tribunal noted that Dr Tudor suggested he had prescribed Cosmofer because the patient was unable to tolerate oral iron. The Tribunal rejected the relevance of this proposition. There is no evidence that this patient had, in fact, been previously prescribed oral iron which had not been tolerated. In any event, the Tribunal accepted Dr AC's evidence that there are many forms of oral iron, which should all be tried if there is intolerance. The next option would have been a referral to a haematologist for an intravenous infusion, not injectable iron, in any event. The Tribunal found that Cosmofer was a very unusual treatment with significant associated risks, including anaphylaxis.

210. In respect of paragraph 5, the Tribunal found that the increase in dose of levothyroxine from 75mcg daily to 100mcg daily was inappropriate. The blood tests taken shortly before showed that Patient B's TSH was slightly low and there was no clinical indication to support this dose increase.

211. The Tribunal therefore found paragraphs 4(a)-(b)(ii), and 5 of the Allegation proved.

Patient C

212. Patient C was a 40 year old woman with a complex past medical history including longstanding chronic fatigue symptoms. She was prescribed various medications by her NHS

surgery including Tramadol and pregabalin for chronic pain. She had chronic problems with insomnia for which she was prescribed amitriptyline 100mcg at night, but she was not regularly prescribed diazepam or similar medication by her NHS surgery.

213. On 2 February 2018 Dr Tudor saw Patient C and took a history of tiredness, cold intolerance and hair loss. Dr Tudor referred to blood test results including:

TSH 0.99 mu/l (Range 0.27-4.20)
T4 13.9 pmol/l (Range 12-22)

214. Dr Tudor started Patient C on levothyroxine 25mcg daily and advised review in 6 weeks. On 16 February 2018 Dr Tudor saw and noted possible hypersensitivity to levothyroxine therefore instructed her to stop taking the same. On 27 March 2018 Dr Tudor saw Patient C. Blood tests were undertaken, showing thyroid function tests of:

TSH 0.98 mu/l (Range 0.27-4.20)
T4 13.7pmol/l (Range 12.0-22.0)

215. On 8 June 2018, Dr Tudor saw Patient C and referred to the previous suspected hypersensitivity to levothyroxine, stating that on cessation 'there was no difference to her symptoms.' Dr Tudor restarted levothyroxine 25mcg daily.

216. In his Rule 7 response, Dr Tudor stated that Patient C presented with multiple symptoms which included weight gain, cold, slow in thought, brain fog, thinning hair. He stated that these symptoms were consistent with a clinical diagnosis of hypothyroidism, that Patient C had other concurrent autoimmune conditions and there was a family history of autoimmune conditions. He was of the opinion that the thyroid function test was suggestive of central hypothyroidism as the T4, T3 and TSH levels were low and felt that it was reasonable to prescribe 25mcg of levothyroxine once daily. Dr Tudor stated that he gradually increased the dosage of levothyroxine gradually in line with symptoms and blood tests.

217. Dr Tudor stated that Dr AC was mistaken when it was alleged that he did not make an appropriate diagnosis of hypothyroidism or appropriately prescribe levothyroxine as the diagnosis was based on signs, symptoms and family history. He stated that Patient C's thyroid function was monitored at regular intervals so that she was not over treated, that he acted in the patient's best interests and always made sure she was safe.

Paragraph 6 of the Allegation

> On 2 February 2018 you consulted with Patient C and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient C's blood results indicating a normal thyroid function. **Found proved**

218. Consistent with similar allegations which the Tribunal was satisfied that Patient C's blood tests did not support Dr Tudor making a diagnosis of hypothyroidism on 2 February

2018, in that they were within the normal reference range. Therefore, the diagnosis of hypothyroidism on 2 February 2018 was not clinically indicated.

219. The Tribunal noted that in Dr Tudor's Rule 7 response, Dr Tudor stated that his diagnosis of hypothyroidism and subsequent prescription of levothyroxine was based on signs, symptoms and family history. It noted that Dr Tudor's approach is contrary to the guidance of the RCP, as already set out in this determination, in which it states that a diagnosis of hypothyroidism must be based on blood tests. Dr Tudor's approach of relying on signs, symptoms and family history is not an appropriate basis for a diagnosis, as set out in the guidance.

220. The Tribunal therefore found paragraph 6 of the Allegation proved.

Paragraphs 7(a)-(c) of the Allegation

On one or more of the dates set out in Schedule 3 you failed to:

(a) prescribe appropriately in that you:

(i) prescribed Levothyroxine for Patient C when it was not clinically indicated; **Found proved**

(ii) inappropriately increased the dose of Levothyroxine without undertaking further blood tests to see if Patient C's thyroid function had improved; **Found proved**

(b) obtain informed consent from Patient C in that you did not advise Patient C:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

(ii) of the potential for Patient C to experience serious side-effects; **Found not proved**

(c) make a record of having undertaken the actions referred to at paragraph 7b. **Found proved**

221. In respect of paragraph 7(a)(i), for the same reason as it has set out previously in respect of similar allegations, the diagnosis of hypothyroidism was not clinically indicated on 2 February 2018 and therefore the initial prescription of levothyroxine to treat that hypothyroidism was also not appropriate nor clinically indicated.

222. The Tribunal noted that Dr Tudor referred to a number of blood test results over the period covered by Schedule 3. All remained within the normal range in terms of thyroid

function. The Tribunal was satisfied that there was no new clinical information or blood test results subsequent to 2 February 2018, to indicate that there was any change to Patient C's thyroid function.

223. In respect of paragraph 7(a)(ii), the Tribunal was of the view that throughout the period of prescriptions of levothyroxine, as set out in Schedule 3, there did not appear to be any justification, in terms of blood test results, to indicate changes to the dosage of levothyroxine as the T4 and TSH levels appeared to be within the normal reference ranges.

224. The Tribunal had regard to the fact that there was a suggestion by Dr Tudor that the last two prescriptions appearing on Schedule 3 were issued by a Dr AE. For reasons already set out, the Tribunal placed little weight on this evidence from Dr Tudor, which could not be challenged by the GMC. The Tribunal also noted that this was not an issue raised by Dr Tudor in his Rule 7 responses, notwithstanding the detail with which he addressed many other issues.

225. In respect of paragraphs 7(b)(i) and (ii), and 7(c), the Tribunal found that the record made by Dr Tudor included no mention of him having obtained informed consent from Patient C relating to the decision to prescribe levothyroxine contrary to relevant guidance, and as to the potential serious side effects she may experience. He made no comment in his Rule 7 response that informed consent had been obtained.

226. For the same reasons as set out in respect of paragraphs 2(b) and (c) of the Allegation, the Tribunal was of the view that, on a balance of probabilities, the GMC had failed to establish that Dr Tudor had failed to obtain informed consent. The Tribunal determined that the GMC had not proven its case on the balance of probabilities.

227. The Tribunal therefore found paragraphs 7(a)(i) and (ii), and 7(c) proved, and paragraphs 7(b)(i) and (ii) of the Allegation not proved.

<u>The prescribing of diazepam to Patient C</u>

228. On 31 July 2018, Dr Tudor issued a 'repeat prescription' for medication including levothyroxine 50mcg daily, with no rationale given for the increased dose. Dr Tudor also prescribed diazepam 5mg three times daily x 100 tablets with no rationale for this prescription given. On 3 October 2018 Dr Tudor saw Patient C and referred to her still being tired so, increased her levothyroxine dose up to 100mcg daily. Dr Tudor arranged to take blood tests, and also continued to prescribe diazepam 5mg three times daily x 100, with the record suggesting that this medication had been prescribed for Patient C's head and neck pain.

229. On 18 January 2019 Dr Tudor prescribed levothyroxine 100mcg daily x 30 and diazepam 5mg three times daily x 100. On 14 March 2019 Dr Tudor saw Patient C and his record stated:

"[Patient C] has requested a prescription for Diazepam… She wondered if she could increase the dose of Diazepam – but this is in-advisable because Diazepam is addictive."

230. On 26 March 2019 Dr Tudor saw Patient C and, it is stated, declined a further request for increased diazepam. Dr Tudor also responded to a request for a prescription of diazepam on 2 April by asking the pharmacist not to dispense diazepam. On 18 September 2019 a further prescription of diazepam 5mg three times daily x 100 issued. On 28 September 2019 Dr Tudor reissued the diazepam on the basis that Patient C had 'lost' them.

231. On 4 November 2019 Patient C was seen at an NHS Accident and Emergency department with an accidental overdose of propranolol 40mg x 8 tablets and diazepam 5mg x 8 tablets [taken] to try to sleep.

232. In his Rule 7 response, Dr Tudor stated that in July 2018 he prescribed Patient C 5mg of diazepam to help with neck pain and stiffness due to muscle spasm. He said that the diazepam helped Patient C's symptoms to some degree, that he had emphasised to her that they were only for short term use as they were addictive and that this treatment continued, albeit on a reducing dose basis.

233. Dr Tudor stated that his prescribing of 5mgs of diazepam was entirely justified at the time, though he accepted that it was not consistent with the relevant GMC guidelines. He said that the treatment was not below the standard expected of a reasonably competent GP. Dr Tudor said that Patient C's GP was provided with copies of his session notes and blood tests on regular intervals and in turn, the NHS GP provided him with copies of her NHS medical records.

234. The Tribunal had regard to the BNF when considering the allegations in respect of diazepam. It noted that diazepam was a benzodiazepine, and could be used in the treatment of muscle spasms. Diazepam is a controlled drug and Dr AC told the Tribunal it was not a drug that not many GPs would prescribe. The Tribunal accepted this evidence.

235. In respect of diazepam, the BNF stipulates that:

"Diazepam

- *INDICATIONS AND DOSE*

Muscle spasm of variety aetiology

- *BY MOUTH*
- *Adult: 2-15mg daily in divided doses, then increased as necessary to 60mg daily, adjusted according to response, dose only increased in spastic conditions"*

236. In the NICE guidelines for 'Controlled drugs: safe use and management' published 12 April 2016, it which it stated:

*"1.5 **Prescribing controlled drugs***

The recommendations in this section are for all health professionals prescribing controlled drugs unless otherwise stated.

Making and recording prescribing decisions

1.5.1 When making decisions about prescribing controlled drugs take into account:

- *the benefits of controlled drug treatment*
- *the risks of prescribing, including dependency, overdose and diversion*
- *all prescribed and non-prescribed medicines the person is taking (particularly any centrally acting agents) and whether the person may be opioid naïve*
- *evidence-based sources, such as NICE and the British national formulary (BNF), for prescribing decisions when possible.*

1.5.2 When prescribing controlled drugs:

- *document clearly the indication and regimen for the controlled drug in the person's care record*
- *check the person's current clinical needs and, if appropriate, adjust the dose until a good balance is achieved between benefits and harms*
- *discuss with the person the arrangements for reviewing and monitoring treatment*
- *be prepared to discuss the prescribing decision with other health professionals if further information is requested about the prescription.*

…

1.5.5 Prescribe enough of a controlled drug to meet the person's clinical needs for no more than 30 days. If, under exceptional circumstances, a larger quantity is prescribed, the reasons for this should be documented in the person's care record.

1.5.7 When prescribing controlled drugs outside general practice (for example in hospital or out of hours), inform the person's GP of all prescribing decisions and record this information in the person's care record so the GP has access to it. When sharing information take into account the account the following 5 rules:

- *Confidential information about service users or patients should be treated confidentially and respectfully.*

- *Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.*
- *Information that is shared for the benefit of the community should be anonymised.*
- *An individual's right to object to the sharing of confidential information about them should be respected.*
- *Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed.*

  …

Providing information and advice to people taking or carers administering controlled drugs

1.5.9 Document and give information to the person taking the controlled drug or the carer administering it, including:

· *how long the person is expected to use the drug*
· *how long it will take to work*
· *what it has been prescribed for…"*

Paragraphs 8(a)-(b) of the Allegation

On one or more of the dates set out in Schedule 4 you inappropriately prescribed diazepam for Patient C in that you prescribed it:

(a) outside of:

(i) BNF guidance; **Found not proved**

(ii) NICE guidance on the management of controlled drugs; **Found proved**

(b) without recording your rationale for doing so. **Found Proved**

237. Within the medical record for 7 July 2018, Dr Tudor records that Patient C was suffering from left neck pain and stiffness and makes reference to frontal headaches. He did not however make any express reference to muscle spasms, or to the prescribing of diazepam. On 31 July 2018 Dr Tudor issued a repeat prescription which included diazepam 5mg TDS x100, without any rationale or clinical indication recorded. It was not until Dr Tudor's Rule 7 response to the allegation in which he then stated that the prescription was to help with Patient C's neck pain and stiffness, the latter of which being due to muscle spasm. In the Tribunal's judgment, it was not at all clear what diagnosis had been made, and to what

condition the prescription of diazepam was associated. This is particularly inappropriate in the case of a controlled drug.

238. Whilst the prescription of 15mgs daily was within the parameters set within the BNF, the Tribunal was of the view that in every other aspect, the prescribing of diazepam fell outside of the NICE guidance. In respect of paragraph 8(a), Dr Tudor accepted that his prescribing of diazepam to Patient C was not consistent with GMC guidance in his Rule 7 response. The Tribunal was satisfied that there was no note within the medical record of Dr Tudor's rationale at the start of the treatment, or thereafter for treating Patient C with a controlled drug.

239. The Tribunal therefore found paragraph 8(a)(i) not proved, and paragraphs 8(a)(ii) and 8(b) of the Allegation proved.

Paragraph 9 of the Allegation

> Between 2 February 2018 and 19 May 2020 you failed to communicate your prescribing of medication for Patient C to her NHS GP. **Found proved**

240. In his Rule 7 response, Dr Tudor said that Patient C's GP was provided with copies of his session notes and blood tests on regular intervals and in turn, the NHS GP provided him with copies of her NHS medical records.

241. The Tribunal had before it a letter, on TMM letter headed paper, in respect of Patient C, which stated:

> *"Dear Doctor,*
>
> *I have seen your patient in the clinic Tudor Medical Matters recently.*
>
> *For your information I enclose copies of the session notes, relevant blood test results and prescription issued for their NHS GP records.*
>
> *In turn - in the interests of the patient - I would be most grateful if you could provide me with a copy of your computerised GP records. These can be emailed to us at…*
>
> *If you require any further details, please do not hesitate to contact me directly."*

242. The Tribunal noted that this letter was not specific addressed and was undated. Additionally, there was another letter before it with similar omissions. There was no record of the NHS GP having received any such letter, from 2 February 2018 up until 19 May 2020, from Dr Tudor or TMM. There is no mention in Dr Tudor's notes of any attempt to communicate with the NHS GP during the relevant period. The Tribunal found that no such communication had taken place.

243. The Tribunal therefore found paragraph 9 of the Allegation proved.

Patient D

244. The Tribunal found that at the relevant time, Patient D was a 60 year old woman with a history of hiatus hernia and chronic back problems. On 15 December 2017 Dr Tudor saw Patient D and took a history of memory problems 'for about 18 months' along with tiredness and hair loss. Dr Tudor took a blood sample from Patient D. The blood test results were:

TSH 1.87 mu/l	(Range 0.27-4.20)
Free Thyroxine (T4) 14.0 pmol/l	(Range 12.0 – 22.0)
Free T3 3.9 pmol/l	(Range 3.10-6.80)

Thyroid antibodies were normal

245. On 13 April 2018 Dr Tudor saw Patient D and took a history that her symptoms appear to be worse and a prescription of levothyroxine 25mcg once daily was issued. On 9 May 2018 Dr AK, a GP from Patient D's NHS surgery, saw Patient D and discussed the diagnosis of hypothyroidism made by Dr Tudor. Dr AK stated that the blood test results brought to the appointment by Patient D did not, in her opinion, support the proposed diagnosis.

246. On 17 May 2018 Dr AO, another GP at the surgery, saw Patient D and discussed her recent blood tests, including a TSH of 0.63mu/l (range 0.3-6) which was stated to be normal. Dr AO stated that Patient D had not taken the medication from Dr Tudor.

247. In his Rule 7 response, Dr Tudor stated that Patient D had presented with multiple symptoms and that he arranged for her to have a thyroid function test which was abnormal. He stated that he then prescribed 25 mcg of levothyroxine once a day as it was clinically indicated and had no potential whatsoever to cause serious side effects to Patient D, in his opinion.

Paragraphs 10(a)-(d) of the Allegation

On or around 13 April 2018 you consulted with Patient D and you failed to:

(a) make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient D's blood results indicating a normal thyroid function;
Found proved

(b) prescribe appropriately for Patient D in that you prescribed Levothyroxine 25mcg once daily when it was not clinically indicated;
Found proved

(c) obtain informed consent from Patient D in that you did not advise Patient D:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; Found not proved

(ii) of the potential for Patient D to experience serious side-effects; Found not proved

(d) make a record of having undertaken the actions referred to at paragraph 10c. Found proved

248. In respect of paragraph 10(a), the Tribunal were satisfied that the blood tests results on 15 December 2017 did not indicate hypothyroidism. The relevant readings were within the normal ranges. The Tribunal did not therefore accept, as stated by Dr Tudor, that this patient's thyroid function was abnormal and that she had hypothyroidism.

249. In respect of paragraph 10(b), consistent with similar findings the Tribunal has made in this determination, where the initial diagnosis of hypothyroidism was not clinically indicated, treatment for that condition with levothyroxine was also not therefore indicated and any such prescription in that regard would be inappropriate.

250. In respect of paragraph 10(c)(i) and (ii), and 10(d), for the same reasons as set out in respect of paragraphs 2(b) and (c) of the Allegation, the Tribunal was of the view that, on a balance of probabilities, the GMC had failed to establish that Dr Tudor had failed to obtain informed consent. The Tribunal determined that the GMC had not proven its case on the balance of probabilities. However, it was satisfied that Dr Tudor had not made an appropriate record in the medical notes of these matters.

251. The Tribunal therefore found paragraphs 10(a), (b) and (d) proved, and paragraphs 10(c)(i) and (ii) of the Allegation not proved.

Patient E

252. The Tribunal found that Patient E was a 48 year old woman with a complex past medical history including severe knee osteoarthritis causing chronic pain, for which she underwent surgery. She received multiple treatments from her NHS surgery, including taking Oramorph, a liquid form of morphine sulphate (an opiate), for chronic pain.

253. On 9 April 2018 Patient E had blood tests at her NHS surgery that showed:

TSH 0.45 mu/l	(Range 0.30 – 6.00)
Haemoglobin (Hb) 111g/l	(Range 115-165)

254. The low Hb level was consistent with a mild iron deficiency anaemia. On 14 April 2018 Dr Tudor saw Patient E and took a history of longstanding tiredness, hair loss and weight gain. Multiple other symptoms were also considered. Dr Tudor did not refer to the results of any blood tests but asked that Patient E provide a copy of blood tests from her NHS surgery. Dr Tudor made a diagnosis of Hashimoto's and started treatment with levothyroxine 25mcg tablets once daily and advised review with repeat thyroid function in 6 weeks' time.

255. On 24 April 2018 Dr Tudor saw Patient E and noted that Patient E's aunt had had a thyroid disorder. Dr Tudor also referred to photographs of Patient E showing a goitre. Dr Tudor advised Patient E that levothyroxine dose should be increased to 50mcg daily.

256. In his Rule 7 response, Dr Tudor stated that Patient E presented with multiple symptoms which included pale olive skin, thyroid swelling, synovial joint swelling, epigastric tenderness, cervical spine tenderness with painful restriction of movement. He said that he requested blood tests which revealed microcytic hypochromic anaemia, TSH of 0.45, low B12 and a folate. He said she was taking morphine sulphate up to 60 mg per day.

257. Dr Tudor stated that Patient E was noted to have a strong family history of thyroid problems. He said that he thought it reasonable to put Patient E on a small dose of levothyroxine as a trial of treatment, initially at 25mcg once a day, increased to 50 mcg once a day. He said that Patient E's symptoms referable to hypothyroidism improved. He said that he communicated with Patient E's NHS GP in that he sent copies of his session notes and blood tests.

Paragraphs 11(a) and (b) of the Allegation

> On 14 April 2018 you consulted with Patient E and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism either:
>
> (a) despite Patient E's blood results indicating a normal thyroid function or; Found proved
>
> (b) without blood results. Found proved

258. The Tribunal was satisfied that there was no justification for a clinical diagnosis for hypothyroidism as the blood tests were within the normal reference range, as set out by Dr AC. Furthermore, at the time of diagnosis and prescription of levothyroxine, there was no evidence to suggest that Dr Tudor had the results of any blood test before him. The Tribunal determined that Dr Tudor did therefore fail to make an appropriate diagnosis of hypothyroidism without blood results. The Tribunal further found that it was inappropriate to 'trial' a drug of this kind. It was satisfied that the diagnosis had been based in symptoms and family history, an approach which is contrary to the relevant guidance.

259. The Tribunal therefore found paragraphs 11(a) and (b) of the Allegation proved.

Paragraphs 12(a)-(c) of the Allegation

On one or more of the dates set out in Schedule 5 you failed to:

(a) prescribe appropriately in that you:

(i) prescribed Levothyroxine for Patient E when it was not clinically indicated; **Found proved**

(ii) inappropriately increased the dose of Levothyroxine:

(1) without undertaking further blood tests to see if her thyroid function had improved; **Found proved**

(2) despite recent blood results indicating a normal thyroid function; **Found proved**

(b) obtain informed consent from Patient E in that you did not advise Patient E:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

(ii) of the potential for Patient E to experience serious side-effects; **Found not proved**

(c) make a record of having undertaken the actions refer to at paragraph 12b. **Found proved**

260. For all the reasons previously set already in this determination, the Tribunal found that the prescribing of levothyroxine when a diagnosis of hypothyroidism was not clinically indicated as the blood tests were normal was not appropriate.

261. The Tribunal noted that whilst there was no reference to any blood results on 28 April 2018, there was some reference to blood tests on 11 May 2018, but it appeared they were in relation to anaemia and not thyroid function tests. On 13 June 2018 Dr Tudor increased the levothyroxine dose to 75mcg, though it was only recorded in the medical notes on 27 June 2018. This increase was without any reference to any blood test results that the Tribunal could see. He gave a repeat prescription on 10 July for 50mcg of levothyroxine and then on 4 August 2018 there is a note in the medical record referring to 'see Medichecks result', but there was no record of any results. On 6 November 2018 levothyroxine was increased to 100mcg and again, there was no reason in the medical notes or reference to any blood test results, and a further increase to 125mcg on 23 April 2019, with no reasoning given or reference to blood test results.

262. There were blood test results on 11 July 2018 and 8 April 2019 which demonstrate normal thyroid function. The Tribunal also had before it blood test results from the NHS GP for Patient E on 12 April 2019, though Dr Tudor never referred to them in his medical notes.

263. Dr Tudor therefore increased the dosage of levothyroxine on four occasions in a 15 month period without any rationale or reference to any blood results which indicated an abnormal thyroid function. The Tribunal could find no supporting blood test results to justify any of the prescriptions set out at Schedule 5.

264. In respect of paragraph 12(b)(i) and (ii) and 12(c), for the same reasons as set out in respect of paragraphs 2(b) and (c) of the Allegation, the Tribunal found that Dr Tudor had obtained informed consent following his decision to prescribe levothyroxine contrary to relevant guidance and of the potential of Patient E to experience serious side effects. The Tribunal determined that the GMC had not proven its case on the balance of probabilities. However, it was satisfied that Dr Tudor had not made an appropriate record in the medical notes of these matters.

265. The Tribunal therefore found paragraphs 12(a)(i), (ii), (1) and (2), and 12(c) proved, and paragraphs 12(b)(i) and (ii) of the Allegation not proved.

The prescribing of Cosmofer to Patient E in relation to iron deficiency anaemia

266. On 13 June 2018 Dr Tudor saw Patient E and stated that a full blood count showed features consistent with 'iron deficiency anaemia.' Dr Tudor gave an injection of Cosmofer 50mg/ml 2mls into the right buttock and an injection of Vitamin B12. On 17 October 2018 Dr Tudor saw Patient E and Oramorph 10mg/5mls 20mls four times daily x 2000mls was issued. Dr Tudor gave an injection of Cosmofer 50mg/ml 2mls into the right buttock.

267. On 21 March 2019 Dr Tudor saw and encouraged Patient E to reduce her Oramorph use from 125mls per day to 80mls per day and discussed further proposed reduction. Dr Tudor gave Patient E an injection of Cosmofer 50mg/ml 2mls into the right buttock.

268. In his Rule 7 response, Dr Tudor said that he requested blood tests which revealed microcytic hypochromic anaemia, TSH of 0.45, low B12 and a folate. He said that Patient E continued to suffer from iron deficiency anaemia and so he prescribed a one-off dose of Cosmofer.

Paragraphs 13(a)-(c) of the Allegation

> You prescribed and/or administered a Cosmofer injection for Patient E when this was not clinically indicated on:
>
> (a) 13 June 2018; **Found proved**
>
> (b) 17 October 2018; **Found proved**

(c) 21 March 2019. **Found proved**

269. The Tribunal found that on 9 May 2018 Dr AP, a NHS GP, saw Patient E and made a diagnosis of iron deficiency anaemia on a basis of appropriate blood test results and had been prescribed an oral form of iron. Dr Tudor did not prescribe Cosmofer appropriately on 13 June 2018, 17 October 2018 and 21 March 2019. Patient E's records contained no indication that it was necessary for her to be given an injectable form of iron as treatment. Generally, injectable iron would only be considered where a patient had a severe form of iron deficiency or there was established intolerance to oral iron supplements. There is nothing to suggest that this was the case. Indeed, both before and after the Cosmofer injections were administered by Dr Tudor, prescriptions for oral iron were given to Patient E. Intramuscular injections of iron carry risks, such as anaphylaxis, and local complications at the injection site such as staining of the skin, bleeding, formation of sterile abscesses, tissue necrosis or atrophy and pain. Patient E was placed at risk of side effects by Dr Tudor when there was no reason to do so.

270. Despite Dr Tudor's account in his Rule 7 response that he only administered a one-off Cosmofer injection, the evidence before the Tribunal demonstrated that Dr Tudor administered Cosmofer injections on 13 June 2018, 17 October 2018 and 21 March 2019. The Tribunal rejected his account.

271. The Tribunal therefore found paragraphs 13(a), (b) and (c) of the Allegation proved.

Paragraph 14 of the Allegation

Between 14 April 2018 and 11 June 2019 you failed to communicate your prescribing of opiates for Patient E to her NHS GP. **Found proved**

272. In his Rule 7 response, Dr Tudor stated that Patient E was taking morphine sulphate up to 60 mg per day, that she had continuing joint pain, in particular knee pain. He referred her to a Consultant Orthopaedic surgeon and an MRI scan revealed bone on bone. Patient E had a total knee replacement.

273. Dr Tudor said that he eventually asked Patent E to leave the practice as he found out she was obtaining morphine sulphate from both him and her NHS GP. He said that he communicated with Patient E's NHS GP, sent over all his session notes and blood tests and had a conversation with someone at her GP Practice regarding the prescription for morphine sulphate. He said that in this case he believed he had acted correctly and certainly not below the standard expected of a reasonable competent doctor.

274. The Tribunal found insufficient evidence that Dr Tudor had communicated with Patient E's NHS GP between 14 April 2018 and 11 June 2019, despite Dr Tudor Rule 7 account. The Tribunal considered that it would have been helpful had Dr Tudor attended the

hearing and given evidence. As it was, there was nothing to support his account, either in his own notes, or those of the NHS GP.

275. Whilst the opiates Dr Tudor prescribed to Patient E were not a controlled drug, the Tribunal noted that there was a clear danger if patients received opiates from both a private GP and an NHS GP, where there has been no communication from the private GP.

276. The Tribunal therefore found paragraph 14 of the Allegation proved.

Patient F

277. The Tribunal found that Patient F was a 49 year old woman with a history of tiredness and iron deficiency. On 14 February 2019 Dr Tudor saw Patient F and took a history of tiredness and cold intolerance. Dr Tudor obtained a blood sample and prescribed levothyroxine 50mcg daily. On 15 February 2019 Patient F's blood tests were returned showing thyroid function tests of:

TSH 0.763 mu/l	(Range 0.27-4.20)
T3 4.94 pmol/l	(Range 3.1 – 6.8)
T4 19.1 pmol/l	(Range 12.0 – 22.0)

278. On 12 June 2019 and 9 October 2019 Dr Tudor issued prescriptions of levothyroxine 100mcg daily. No rationale was given for the change of dose. On 1 November 2019 Dr Tudor made an entry in Patient F's records stating *"For some reason she has been given Levothyroxine 100mcg tablets – she should be on 50mcg tablets. Has been trying to break them in half!".* Dr Tudor then issued a prescription of levothyroxine 50mcg daily.

279. On 3 March 2020 and 19 May 2020 Dr Tudor issued prescriptions of levothyroxine 100mcg daily. On 19 May 2020 had blood tests showing thyroid function of:

TSH 0.66 mu/l	(Range 0.27-4.20)
T4 19.8 pmol/l	(Range 12.0 – 22.0)

280. In his Rule 7 response, Dr Tudor stated that Patient F presented with a history of anxiety attacks and agoraphobia, depression and tired all the time, brain fog, weight gain, feeling cold, recurrent URTI's ('upper respiratory tract infections'), abdominal bloating and joint pain.

281. Dr Tudor stated that brain fog, feeling cold and weight gain were symptoms of hypothyroidism. He said that he felt it was reasonable to put Patient F on a trial of 50 mcg of levothyroxine once a day despite normal thyroid function tests results and that her symptoms then dramatically improved.

282. Dr Tudor stated that he informed Patient F that his decision to prescribe her levothyroxine was contrary to the relevant guidance and that there was the potential for

levothyroxine to cause side effects. He said that on occasions he repeated blood tests for monitoring purposes and that he kept her NHS GP informed.

283. Dr Tudor accepted that Patient F was prescribed 100 mcg tablets of levothyroxine on one occasion in error. He said Patient F did not take them, rather she had tried to break them in half and that the error was immediately rectified.

Paragraphs 15(a)-(d) of the Allegation

On 14 February 2019 you consulted with Patient F and you failed to:

(a) make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient F's blood results indicating a normal thyroid function; **Found proved**

(b) prescribe appropriately for Patient F in that you prescribed Levothyroxine 50mcg daily when it was not clinically indicated; **Found proved**

(c) obtain informed consent from Patient F in that you did not advise Patient F:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

(ii) of the potential for Patient F to experience serious side-effects; **Found not proved**

(d) make a record of having undertaken the actions referred to at paragraph 15c. **Found proved**

284. The Tribunal noted that blood tests were taken on 14 February 2019 and were returned on 15 February 2019 indicating that Patient F's TSH, T4 and T3 levels were within the normal range. Dr Tudor acknowledged that he had based the diagnosis on symptoms, and that prescribing levothyroxine on that basis was outside of normal guidance. He stated that he had advised the patient of this fact. The Tribunal was satisfied that this was contrary to appropriate practise and the RCP guidance. It was not clear whether the blood results were available at the time of the original diagnosis. However, either way, Dr Tudor's conduct was inappropriate.

285. The Tribunal was satisfied that Dr Tudor failed to prescribe appropriately for Patient F in that he prescribed levothyroxine 50mcg daily when it was not clinically indicated on 14 February 2019.

286. In respect of paragraphs 15(c)(i) and (ii), and 15(d), the Tribunal was mindful that Dr Tudor did not have to prove anything and that the burden was on the GMC to prove that Dr Tudor did not obtain informed consent and advise Patient F in respect of the potential for side effects. For the reason previously set out, the Tribunal determined that the GMC had not proven its case on the balance of probabilities. However, it was satisfied that Dr Tudor had not made an appropriate record in the medical notes of these matters.

287. The Tribunal therefore found paragraphs 15(a), (b) and (d) proved, and paragraphs 15(c)(i) and (ii) of the Allegation not proved.

Paragraphs 16(a) and (b) of the Allegation

> On 12 June 2019 you consulted with Patient F and you failed to prescribe appropriately in that you increased the dose of Levothyroxine for Patient F:
>
> (a) when it was not clinically indicated; **Found proved**
>
> (b) without undertaking further blood tests to see if her thyroid function had improved. **Found proved**

288. The Tribunal noted that on 27 March 2019 Dr Tudor had prescribed Patient F 50mcg of levothyroxine, and then, without any rationale recorded in the medical notes, increased that dosage to 100mcg on 12 June 2019. The Tribunal considered that there was no clinical indication initially for a diagnosis of hypothyroidism and therefore no clinical indication for the prescription of levothyroxine. It also noted that there was no subsequent blood tests requested by Dr Tudor indicating that Patient F had abnormal thyroid function. The Tribunal was satisfied that given Patient A did not have hypothyroidism, she should not have been on levothyroxine in the first place, and that there was no evidence to suggest anything had changed. In other words, the medication should have been stopped and not increased.

289. The Tribunal therefore found paragraphs 16(a) and (b) of the Allegation proved.

Patient G

290. The Tribunal found that Patient G was a 51 year old woman with a complex past medical history including chronic fatigue and various abdominal symptoms. On 5 June 2018 Mr AA, an NHS GP saw Patient G and arranged for blood tests to be undertaken. The tests included:

TSH 2.6	(Range 0.3-6.0)
Hb 110	(Range 115-165)
MCV 85 fL	(Range 76-100)
MCV 26.6pg	(Range 27-32)
Ferritin 10ug/l	(Range 10.0 – 291.0)

291. On 14 July 2018 Dr Tudor saw Patient G with tiredness and cold intolerance. The blood tests undertaken by the NHS surgery were considered. Dr Tudor, by implication, diagnosed hypothyroidism and started treatment with levothyroxine 25mcg daily. On 15 August 2018 Dr Tudor saw Patient G and took a history of improved symptoms. Dr Tudor increased Patient G's levothyroxine to 50mcg daily.

292. On 29 August 2018 Dr Tudor saw Patient G and referred to blood test results. These included:

TSH 1.27 mu/l	(Range 0.27 - 4.20)
T4 13.2 pmol/l	(Range 12.00 – 22.00)
T3 4.79 pmol/l	(Range 3.10-6.80)
Hb 124	(Range 115-165)

293. Dr Tudor increased Patient G's levothyroxine to 100mcg daily. On 15 January 2019 Dr Tudor took a blood test from Patient G. The sample was reported on 17 January 2019 and included:

TSH <0.005 mu/l	(Range 0.27-4.20)
T4 28.20 pmol/l	(Range 12-22)
T3 7.75 pmol/l	(Range 3.1-6.8)

294. These results were grossly abnormal, showing that Patient G was significantly hyperthyroid due to overtreatment with levothyroxine. On 6 February 2019 Dr Tudor saw Patient G and reduced her dose of levothyroxine to 75mcg daily, presumably in response to the previous abnormal blood test result. On 16 April 2019 Dr Tudor saw Patient G and continued her treatment and took a blood sample. The sample was reported on 17 April 2019 and included:

TSH 0.052 mu/l	(Range 0.27-4.20)
T4 20.20 pmol/l	(Range 12-22)
T3 4.99 pmol/l	(Range 3.1-6.8)

295. Again, these results were abnormal, showing that Patient G was significantly over treated with levothyroxine due to her very low TSH level. On 15 May 2019 Dr Tudor saw Patient G and continued her treatment. No reference was made to blood test results.

296. On 31 May 2019 Dr Tudor undertook a telephone consultation with Patient G. Dr Tudor stated that Patient G felt very anxious, emotional, hyperactive, not sleeping, sweating, rapid heart rate, poor temperature regulation and that the blood tests [April 2019] showed overtreatment. Dr Tudor reduced Patient G's levothyroxine dose to 25mcg daily.

297. On 31 July 2019 Dr Tudor saw Patient G and stated: *"See previous TFT. TSH far too low in May [sic] so dose was reduced to Levothyroxine 25mcg [daily. For repeat Blood tests] at the*

end of August". On 6 December 2019 Dr Tudor saw Patient G with 'really bad anxiety.' Blood tests were done, the results of which were referred to:

TSH 0.03 mu/l (Range 0.27 – 4.2)
T4 19.3 pmol/l (Range 12 – 22)

298. Dr Tudor suggested that Patient G reduce levothyroxine to 50mcg [daily] and asked a member of his staff to telephone with this advice. On 19 December 2019 Dr AQ, a private gastroenterologist, saw Patient G with various abdominal symptoms including diarrhoea and weight loss of over 2 stone in the preceding five months. Dr AQ referred to various investigations undertaken for Patient G including a CT colonography, which was normal. Dr AQ commented on Patient G's treatment for hypothyroidism:

> *"She is being treated for Hashimoto's thyroiditis and the blood test you kindly included in the referral indicated that she is over treated with thyroxine. She has a TSH of less than 0.3 [Sic – this was actually 0.03] and I think that this is significant as it may be that this is responsible for her weight loss and diarrhoea."*

299. In his Rule 7 response, Dr Tudor stated that Patient G presented with auto immune symptoms: 1) tired all the time, sluggish thoughts, feeling cold, dry skin on her feet, possible hypothyroidism; 2) abdominal pain associated with bloating, possible IBS 3) epigastric pain.

300. Dr Tudor noted that Patient G's daughter had an autoimmune condition. He stated that Patient G's GP blood tests revealed microcytic hypochromic anaemia Ferritin 10 and features suggestive of metabolic syndrome i.e., abnormal lipids. Her TSH was 2.6.

301. Dr Tudor said that he decided to put her on a trial of levothyroxine 25 mcg once daily due to her symptoms. He said that when he saw Patient G four weeks later, she told him that she felt good, that she had not felt as good as that for years. Dr Tudor stated that test results showed TSH 1.27, T4 13.2, and T3 4.79. He stated that the T3 and T4 levels were low and because of that he increased the dose of levothyroxine to 75 mcg once daily. He said that this was evidence of satisfactory treatment.

302. Dr Tudor admitted that in respect of 15 January 2019 and 16 December 2019, Patient G was found to have been overtreated with levothyroxine. As a result, the dose of levothyroxine Patient G was prescribed was reduced.

303. Dr Tudor stated that Patient G's Hb HCT MCH serum Iron Transferrin and Ferritin levels remained low. He said that because of significant gastritis symptoms, Patient G was unable to tolerate oral iron. He stated that it was for this reason that he prescribed Cosmofer injections. Dr Tudor said that this was clinically indicated in his opinion and that he counselled her before each injection.

304. Dr Tudor refuted the suggestion that he had acted below the standard expected of a reasonably competent GP with regard to his diagnosis and treatment of hypothyroidism. Dr Tudor stated that he had always acted in the best interests of the patient.

305. Dr Tudor said that Patient G was informed that the decision to prescribe levothyroxine was based on symptoms, family history of autoimmunity, and the low T4 and T3 levels, rather than relevant guidance such as a raised TSH level. He said he told her that there was potential for levothyroxine to cause serious side effects although any side effects would be minimal because the dose of levothyroxine was relatively low.

Paragraphs 17-18(c) of the Allegation

17. On 22 February 2019 you consulted with Patient G and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient G's blood results indicating a normal thyroid function. **Found not proved**

18. On one or more of the dates set out in Schedule 6 you failed to:

(a) prescribe appropriately for Patient G in that you:

(i) prescribed Levothyroxine when it was not clinically indicated; **Found proved**

(ii) increased the dose of Levothyroxine for Patient G:

(1) without undertaking further blood tests to see if her thyroid function had improved; **Found proved**

(2) despite recent blood results indicating a normal thyroid function; **Found proved**

(b) obtain informed consent from Patient G in that you did not advise Patient G:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

(ii) of the potential for Patient G to experience serious side-effects; **Found not proved**

(c) to make a record of having undertaken the actions referred to at paragraph 18b. **Found proved**

306. The Tribunal found that Dr Tudor did not consult with Patient G on 22 February 2019, as stated in paragraph 17 of the Allegation. It appeared to the Tribunal that Dr AC may have

transposed the date incorrectly in his expert report and that the error had unwittingly adopted in the Allegation. The date is a material averment in this case. The charge is therefore not made out.

307. In respect of paragraphs 18(a)(i), (ii) (1) and (2), the Tribunal found that Dr Tudor first diagnosed Patient G with hypothyroidism on 14 July 2018. This was also the date when he first prescribed 25mcg of levothyroxine once daily to Patient G. This is the first date in Schedule 6.

308. The Tribunal had regard to the blood test results of 5 June 2018, which showed normal thyroid function. Dr Tudor justified his diagnosis of hypothyroidism on the basis of signs, symptoms and family history, not on the results of blood tests contrary to the RCP guidance. The Tribunal was satisfied therefore that the prescription of levothyroxine in the first instance was not clinically indicated. The Tribunal found that the fact of the patient expressing an improvement in symptoms (if it be true) did not justify what was otherwise an inappropriate diagnosis and prescription.

309. In relation to the other dates set out in Schedule 6, the Tribunal found that there were a number of blood test results for Patient G, including on 29 August 2018, 15 January 2019, 16 April 2019, 27 August 2019 and 6 December 2019. None of these results justified the continuation of levothyroxine in that none were suggestive of hypothyroidism. Indeed, a number of them indicated hyperthyroidism (i.e. low TSH level), which Dr Tudor has admitted was caused by over treatment on levothyroxine.

310. Dr Tudor justified an increase on levothyroxine on 29 September 2019. He said this was clinically indicated as the blood results on 28 August 2019 were T3 13.2 and T4 4.79. The Tribunal did not accept that analysis of the blood result, as both of those markers fell within the normal reference range and the TSH.

311. The Tribunal was satisfied that there was no justification for Dr Tudor increasing the dose of levothyroxine to 100mcg /125mcg once daily, as set out at Schedule 6. It therefore found that Dr Tudor had failed to prescribe appropriately for Patient G, on one or more occasions as set out at Schedule 6, in that he increased the dose of levothyroxine despite recent blood results indicating a normal thyroid function.

312. In respect of paragraph 18(b)(i) and (ii), and 18(c), for the same reasons as set out in respect of paragraphs 2(b) and (c) of the Allegation, the Tribunal found that Dr Tudor had obtained informed consent following his decision to prescribe levothyroxine contrary to relevant guidance and of the potential of Patient G to experience serious side effects. The Tribunal determined that the GMC had not proven its case on the balance of probabilities. However, it was satisfied that Dr Tudor had not made an appropriate record in the medical notes of these matters.

313. The Tribunal therefore found paragraphs 18(a)(i) and (ii), (1) and (2), and 18(c) proved, and paragraphs 17 and 18(b)(i) and (ii) of the Allegation not proved.

Paragraphs 19(a) and (b) of the Allegation

Your actions as described at paragraph 18 caused Patient G to become hyperthyroid as indicated by blood test results taken on:

(a) 15 January 2019; **Found proved**

(b) 6 December 2019. **Found proved**

314. The Tribunal has already made findings that, on these two occasions, Patient G was over treated by Dr Tudor with levothyroxine. Dr Tudor's own admission in his Rule 7 response accepted that the prescription of levothyroxine had to be reduced as Patient G became hyperthyroid as indicated by the blood tests in January 2019 and December 2019.

315. The Tribunal therefore found paragraphs 19(a) and (b) of the Allegation proved.

The prescribing of Cosmofer to Patient G

316. The Tribunal found that on 14 July 2018, Dr Tudor gave an intramuscular injection of Cosmofer into Patient G's right buttock. On 15 August 2018, he gave further injections of Cosmofer. On 6 February 2019 Dr Tudor saw Patient G and advised that she take oral iron supplements, bought 'over the counter.' On 1 March 2019 Dr Tudor saw Patient G and gave her another Cosmofer injection.

317. In his Rule 7 response, Dr Tudor stated that Patient G's iron transferrin and ferritin levels remained low. He said that because of significant gastritis symptoms, Patient G was unable to tolerate oral iron. He stated that it was for this reason that he prescribed Cosmofer injections. Dr Tudor said that this was clinically indicated in his opinion and that he counselled her before each injection.

318. Dr Tudor refuted the suggestion that he had acted below the standard expected of a reasonably competent GP with regard to his treatment the Cosmofer injections in relation to Patient G. Dr Tudor stated that he had always acted in the best interests of the patient.

Paragraphs 20(a), (b) and (c) of the Allegation

You prescribed and/or administered a Cosmofer injection for Patient G when it was not clinically indicated on:

(a) 14 July 2018; **Found proved**

(b) 15 August 2018; **Found proved**

(c) 1 March 2019. **Found proved**

319. The Tribunal accepted Dr AC's opinion that the diagnosis of iron deficiency was a reasonable diagnosis in this case. However, it found that injections of Cosmofer administered to Patient G on three occasions, were not clinically indicated as injectable iron would only be considered where a patient had an extremely severe form of iron deficiency or there was established intolerance to oral iron supplements. Neither of which was the case in the circumstances of Patient G.

320. The Tribunal noted that the serious gastric problem post-dated the first Cosmofer injection. However, there was no evidence to suggest that this patient was tried on oral iron supplements or was found to be intolerant of them. It was the Tribunal's view that Dr Tudor should have tried the patient on iron supplements and that he could not just say that the patient was intolerant when there were a variety of different types of iron supplements available. There was no evidence to suggest that Patient G was tried on any of these. Indeed, it was noted that Dr Tudor had recommended that the patient buy oral iron supplements over the counter on 6 February 2019. This ran contrary to Dr Tudor's Rule 7 observations as to intolerance of oral iron. The Tribunal therefore rejected his account.

321. The Tribunal was of the view that this was a case where there was the potential for severe side effects as previously set out. The Tribunal therefore found paragraph 20 of the Allegation proved.

Patient H

322. The Tribunal found that at the material time, Patient H was a 23 year old woman with a history of fibromyalgia, irritable bowel syndrome and Vitamin B12 deficiency. On 22 February 2019 Dr Tudor saw Patient H and took a detailed history of various symptoms including abdominal pain, joint pain, altered sensations, shortness of breath and chest pains, tiredness and susceptibility to cold. Dr Tudor noted a family history of hypermobility. Dr Tudor did not make a specific diagnosis, but Patient H was prescribed medications including levothyroxine 50mcg daily. Blood tests were undertaken which included:

TSH 2.56 mu/l	(Range 0.27-4.2)
Free T3 5.28 pmol/l	(Range 3.1-6.8)
Free Thyroxine (T4) 13.5pmol/l	(Range 12-22)

323. The thyroid function tests were within the laboratory reference range, and therefore normal.

324. On 13 March 2019 Dr Tudor saw Patient H for a follow up appointment and a history was taken of general improvement, improved joint pains and possible symptoms of endometriosis. No examination was undertaken. Dr Tudor advised an increase of her levothyroxine dose to 75mcg.

325. In his Rule 7 response, Dr Tudor stated that Patient H presented with multiple symptoms, which included hypermobile joint symptoms and hypothyroid symptoms. He said that she had suffered these symptoms since she was 14 years old and that there was a family history of the same. He said that he put Patient H on levothyroxine and Celecoxib and that her symptoms settled. He said that he had not seen Patient H since 24 April 2019 and that he felt that her problems had an autoimmune basis.

326. Dr Tudor stated that given the circumstances he felt it was reasonable to prescribe a trial of treatment for Patient H, which was something he said he had been taught to do. He believed that he had acted in the best interests of Patient H and refuted any suggestion his actions were below the standard of a reasonably competent doctor. Dr Tudor went on to say that his treatment was based on Patient H's family history and examination findings.

Paragraphs 21(a)-(d) of the Allegation

On 22 February 2019 you consulted with Patient H and you failed to:

(a) make an appropriate diagnosis in that you diagnosed hypothyroidism without any blood results; **Found proved**

(b) prescribe appropriately in that you prescribed Levothyroxine 50mcg daily when it was not clinically indicated; **Found proved**

(c) obtain informed consent from Patient H in that you did not advise Patient H:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

(ii) of the potential to experience serious side-effects; **Found not proved**

(d) make a record of having undertaken the actions referred to at paragraph 21c. **Found proved**

327. Patient H was seen by Dr Tudor on 22 February 2019. This was the same day Patient H's bloods were taken to be tested. Dr Tudor did not record an explicit diagnosis of hypothyroidism in Patient H's medical record. However, the Tribunal found that it was likely that he had diagnosed hypothyroidism, as he had prescribed Patient H levothyroxine. This was consistent with his Rule 7 response.

328. The Tribunal was satisfied that the blood test results demonstrated that Patient H had a normal thyroid function and that therefore the diagnosis of hypothyroidism was not appropriate. It followed that the prescription of levothyroxine 50mcg daily was also not clinically indicated. In any event, it was likely that Dr Tudor did not have access to these

results when he prescribed levothyroxine. The Tribunal did not accept that 'trialling' this drug was appropriate in the absence of indicative blood results.

329. In respect of paragraphs 21(c)(i) and (ii), and 21(d), for the same reasons as set out in respect of paragraphs 2(b) and (c) of the Allegation, the Tribunal found that Dr Tudor had obtained informed consent following his decision to prescribe levothyroxine contrary to relevant guidance and of the potential of Patient H to experience serious side effects. The Tribunal determined that the GMC had not proven its case on the balance of probabilities. However, it was satisfied that Dr Tudor had not made an appropriate record in the medical notes of these matters.

330. The Tribunal therefore found paragraphs 21(a), (b) and (d) proved, and paragraphs 21(c)(i) and (ii) of the Allegation not proved

Paragraphs 22(a) and (b) of the Allegation

> On 13 March 2019 you inappropriately prescribed for Patient H in that you increased the dose of Levothyroxine for Patient H:
>
> (a) when it was not clinically indicated; **Found proved**
>
> (b) without undertaking further blood tests to see if her thyroid function had improved. **Found not proved**

331. The Tribunal noted that the entry in the medical for 13 March 2019 appeared to be a direct cut and paste from the medical notes for 22 February 2019, save for the date. This was typical of Dr Tudor's poor record keeping. There was no rationale or reasoning recorded when Dr Tudor increased levothyroxine to 75mcg from 50mcg. The Tribunal found it was not based on blood test results indicating abnormal thyroid function. It was therefore not clinically indicated.

332. The Tribunal noted that there was a blood test obtained by Dr Tudor for Patient H between 22 February 2019 and 13 March 2019. The Tribunal considered that the wording of paragraph 22(b) was therefore not appropriate in the circumstances. Dr Tudor had undertaken further blood tests. In any event, it found that the blood tests were suggestive of normal thyroid function, and therefore did not justify the increase in dose of levothyroxine.

333. The Tribunal therefore found paragraph 22(a) proved, and paragraph 22(b) of the Allegation not proved.

Patient I

334. Patient I was a 26 year old woman with a history of Vitamin B12 deficiency, for which she received Vitamin B12 injections from her NHS surgery. On 10 September 2019 Dr Tudor saw Patient I with multiple symptoms, including widespread joint pains, tiredness, hair loss

and cold intolerance. No relevant family history was noted. Dr Tudor took a blood sample. The blood test showed a normal full blood count, renal function and liver function and:

TSH 1.89 mu/l (Range 0.27-4.2)
T4 16.2 pmol/l (Range 12 – 22)

335. On 12 September 2019 Dr Tudor referred to blood test results and advised that she have treatment with levothyroxine 50mcg daily. On 10 October 2019 Dr Tudor saw Patient I and noted an improvement in her symptoms and 'repeat[ed] all treatment.' On 13 January 2020 Dr AR, a GP at her NHS surgery, saw Patient I and took a history of joint pains and of Dr Tudor's treatment for her condition. Dr AR advised that Patient I stop taking levothyroxine.

336. Dr Tudor stated in his Rule 7 response that on 10 September 2019, Patient I presented with a number of significant autoimmune symptoms, these included joint pain and stiffness aggravated by movement after a period of rest and hip pain. He said Patient I was unable to lie on her side in bed because of this. He said that his diagnosis was hypothyroidism.

337. Dr Tudor stated that he prescribed Patient I a trial of treatment of levothyroxine 50mcg once daily for a short period despite her having normal thyroid function test results. He said that Patient I did not experience any improvements and so he discontinued prescribing her levothyroxine. Dr Tudor stated that he had informed Patient I that prescribing her levothyroxine was contrary to the relevant guidance and that there was the potential for it to cause serious side effects and that she was happy to trial it.

Paragraphs 23(a)-(d) of the Allegation

On or around 12 September 2019 you consulted with Patient I and you failed to:

(a) make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient I's blood results indicating a normal thyroid function; Found proved

(b) prescribe appropriately in that you prescribed Levothyroxine 50mcg once daily when it was not clinically indicated; Found proved

(c) obtain informed consent from Patient I in that you did not advise Patient I:

(i) that the decision to prescribe Levothyroxine was contrary to relevant guidance; Found not proved

(ii) of the potential for Patient I to experience serious side-effects; Found not proved

(d) make a record of having undertaken the actions referred to at paragraph 23c. **Found proved**

338. The Tribunal considered that the blood tests obtained on 10 September 2019 demonstrated that Patient I had normal TSH and T4 levels indicating normal thyroid function. In his Rule 7 response Dr Tudor admitted that Patient I had normal thyroid function and yet diagnosed hypothyroidism based on sign and symptoms. The Tribunal was therefore satisfied that Dr Tudor failed to make an appropriate diagnosis based on the applicable guidelines mentioned above.

339. Having failed to make an appropriate diagnosis in that he diagnosed hypothyroidism, Dr Tudor then prescribed Patient I a trial treatment of levothyroxine 50mcg once daily despite her having normal thyroid function. As already set out in this determination, this prescription was contrary to the guidance and was not clinically indicated.

340. In respect of paragraph 23(c)(i) and (ii), and 23(d), the Tribunal found that the GMC had not proved it case on the obtaining of consent from the patient, but was otherwise satisfied that Dr Tudor had not made an appropriate note of such matters in the patient's records. It made these findings for the same reasons as previously stated.

341. The Tribunal therefore found paragraphs 23(a), (b) and (d) proved, and paragraphs 23(c)(i) and (ii) of the Allegation not proved.

<u>The prescribing of methotrexate to Patient I</u>

342. On 10 September 2019 Dr Tudor saw Patient I with multiple symptoms, including widespread joint pains. On 10 September 2019. Dr Tudor referred to possible treatment with methotrexate, although this was not prescribed. On 17 September 2019 Dr Tudor saw the ex-partner of Patient I who advised Dr Tudor that Patient I had had an exacerbation of joint and limb pain. Dr Tudor gave the ex-partner a prescription of prednisolone 30mg daily.

343. On 24 September 2019 Dr Tudor saw Patient I who's recent episode of inflammatory arthritis had settled. Dr Tudor prescribed methotrexate 12.5mg once weekly. No folic acid was prescribed, and no referral was made to a rheumatologist.

344. On 6 November 2019 Dr Tudor saw Patient I and reported that she had experienced nausea and vomiting which had settled. Dr Tudor also noted some breakthrough vaginal bleeding associated with her present contraceptive pill. Dr Tudor took a blood sample and gave a further repeat prescription. The blood test showed a normal full blood count, renal function and liver function.

345. On 28 November 2019 Dr AS, a GP at her NHS surgery, saw Patient I with heavy and painful vaginal bleeding. A pregnancy test was negative, but she was admitted to hospital with a suspected miscarriage. She was seen in the early pregnancy/gynaecology assessment unit and her vaginal bleeding settled conservatively.

346. On 13 January 2020 Dr AR, a GP at her NHS surgery, saw Patient I and took a history of joint pains and of Dr Tudor's treatment for her condition. Dr AR advised that Patient I stop methotrexate, arranged blood tests and planned to make a rheumatology referral once the blood test results were available. The blood tests showed no evidence of a raised rheumatoid factor or any other inflammatory marker associated with an inflammatory arthritis. On 31 January 2020 Dr AR made a rheumatology referral for Patient I for investigation of possible inflammatory arthritis.

347. On 8 April 2020 Dr AT a GP with a special interest in musculoskeletal medicine saw Patient I and no diagnosis of inflammatory arthritis was made and her treatment with methotrexate was not reinstated.

348. Dr Tudor stated in his Rule 7 response that on 10 September 2019, Patient I presented with a number of significant autoimmune symptoms, these included joint pain and stiffness aggravated by movement after a period of rest and hip pain. He said that his diagnosis was one of inflammatory arthritis, more specifically rheumatoid arthritis.

349. Dr Tudor stated that he prescribed prednisolone but later, because of an exacerbation of her joint symptoms, and as a prednisolone sparing measure, he prescribed methotrexate 12.5mg per week having made sure that Patient I's bloods were monitored before and during treatment.

350. Dr Tudor said that he informed Patient I of the possibility of severe and serious side effects of methotrexate and that he would refer her to a Consultant Rheumatologist. He said that he was not unduly concerned about Patient I conceiving because she was taking Mercilon (an oral contraceptive pill) at the time. He said he advised her not to conceive whilst she was taking the methotrexate.

351. Dr Tudor said that Patient I's joint symptoms improved dramatically whilst she was on her treatment suggesting to him that his diagnosis of rheumatoid arthritis was correct in the first place.

Paragraphs 24(a)(i)-(iv) of the Allegation

On one or more of the dates set out in Schedule 7 you failed to:

(a) prescribe appropriately for Patient I in that you prescribed Methotrexate:

(i) when it was not appropriate for you to do so without input from an appropriately qualified specialist; Found proved

(ii) when Patient I had not been diagnosed with:

(1) rheumatoid arthritis; **Found not proved**

(2) psoriatic arthritis; **Found not proved**

(iii) at a higher dose band than is advised in the BNF guidance: **Found not proved**

(iv) without:

(1) also prescribing folic acid to limit the side effects of Methotrexate; **Found proved**

(2) arranging for Patient I to be monitored before initiation of Methotrexate; **Found not proved**

(3) putting a plan in place for Patient I to be monitored on a weekly/fortnightly basis after initiation of Methotrexate; **Found proved**

(4) advising Patient I's NHS GP of the prescription; **Found proved**

352. The Tribunal found that Dr Tudor had prescribed methotrexate 12.5mg once weekly on 24 September 2019, and a repeat prescription on 10 October 2019 and 6 November 2019, as set out in Schedule 7.

353. The Tribunal again had regard to Dr ACs' oral evidence, in which he identified three things which should be undertaken in diagnosing patients with rheumatoid arthritis. Firstly, clinical assessments, as they were very important in identifying inflammation in the joint. Secondly, a range of blood tests in identifying inflammatory markers in the body. Thirdly, following the blood tests, if indicated, to make an urgent referral to see a rheumatologist or qualified specialist with a special interest in rheumatoid arthritis for their opinion on diagnosis and whether to prescribe methotrexate or a similar treatment.

354. The Tribunal noted that Dr Tudor had indicated to Patient I that he would refer her to a Consultant Rheumatologist. However, there is no evidence to suggest that this took place. The Tribunal was satisfied that Dr Tudor did therefore prescribe methotrexate having failed to obtain the input from an appropriately qualified specialist.

355. In respect of paragraphs 24(a)(ii), Patient I was diagnosed by Dr Tudor, albeit improperly, with inflammatory arthritis which, in the Tribunals view, could mean rheumatoid arthritis or psoriatic arthritis. Whilst the Tribunal did not accept that this was an appropriate diagnosis, it considered that it would not be correct to say there was no diagnosis of rheumatoid arthritis, despite the fact it had been reached through an improper pathway without a qualified specialist's input.

356. In respect of paragraph 24(a)(iii), the Tribunal noted that the BNF indicates that the initiating dose for methotrexate is 7.5-20mg once weekly. Dr Tudor prescribed a starting dose of 12.5mg. It was Dr AC's evidence that the starting dose should have been at the lower end of the initiating dose as set out in the BNF, namely 7.5mg. The Tribunal were of the view that whilst it may have been better to have started Patient I at 7.5mg, a dose of 12.5 was not outside the BNF initiating dose. The Tribunal found therefore that Dr Tudor did not prescribe a higher dose band for methotrexate than advised in the BNF.

357. In respect of paragraph 24(a)(iv)(1), the Tribunal noted that there was no evidence before it in Patient I's medical records to suggest that Dr Tudor prescribed folic acid to limit the side effects of methotrexate, as required by the applicable guidance for this sort of treatment.

358. In respect of paragraph 24(a)(iv)(2), the Tribunal noted that arranging for Patient I to be monitored before initiation of methotrexate was a requirement under the relevant guidance. There was no note in the medical records that Dr Tudor had done so. However, the Tribunal was of the view that this did not necessarily mean he had not made such arrangements for monitoring. The GMC had established that he was not a good record keeper. The burden was on the GMC. The Tribunal determined that, on the balance of probabilities, the GMC had not proven its case.

359. In respect of paragraph 24(a)(iv)(3), the Tribunal could see no evidence before it that Dr Tudor had implemented a plan in place for Patient I to be monitored on a weekly/fortnightly basis after initiation of methotrexate. There appeared to be an almost total absence of appropriate monitoring.

360. In respect of paragraph 24(a)(iv)(4), the Tribunal was satisfied that Dr Tudor had not notified Patient I's NHS GP of the prescription of methotrexate. It noted that the prescription for methotrexate did not become clear to NHS staff until Patient I was admitted to hospital on 28 November 2019 and she was told to stop taking methotrexate and levothyroxine. This lack of communication was clearly inappropriate having regard to the guidance in this area.

361. The Tribunal therefore found paragraphs 24(a)(i) and 24(a)(iv)(1), (2) and (4) proved, and paragraphs 24(a)(ii)(1) and (2), 24(a)(iii) and 24(a)(iv)(2) of the Allegation not proved.

Paragraphs 24(b)-(c) of the Allegation

On one or more of the dates set out in Schedule 7 you failed to:

(b) obtain informed consent from Patient I for the prescription of Methotrexate in that you did not advise Patient I:

(i) of the possibility of serious adverse effects;
Found not proved

(ii) that overdose can be fatal; **Found not proved**

(iii) that regular blood testing is essential; **Found not proved**

(iv) that she should not conceive because Methotrexate is teratogenic; **Found not proved**

(c) make a record of having undertaken the actions referred to at paragraph 24b. **Found proved**

362. The Tribunal noted that there was an absence of any evidence or record within Patient I's medical notes that Dr Tudor had provided this information to Patient I, or that he had obtained informed consent. However, it had already found that this was a doctor who did not take particularly good notes. It considered that the absence of consent having been recorded in the medical record was not determinative as to whether consent had been obtained. It noted that the burden of proof was on the GMC to prove their case and that Dr Tudor did not have to prove anything. The Tribunal determined that the GMC had not positively proven their case in this regard.

363. In respect of paragraph 24(c), as the Tribunal had set out previously, it was satisfied that these were important issues which should have been clearly recorded in the patient's notes. This was not done appropriately.

364. The Tribunal therefore found paragraphs 24(b)(i), (ii), (iii) and (iv) not proved, and paragraph 24(c) of the Allegation proved.

Treatment of family members: Patient J

365. At the time of the events of concern Patient J was a 33 year old woman who had a history of psoriasis. She was XXX and also worked, XXX. Patient J consulted with Dr Tudor between September 2017 and June 2019.

366. On 8 December 2017 Dr Tudor saw Patient J and issued a prescription for citalopram 20mg daily. On 3 January 2018 Dr Tudor saw and recorded that was anxious and tired. Dr Tudor advised an increase of citalopram to 30mg daily.

367. Dr AC assisted the Tribunal in his expert report setting out the following guidance relating to the treatment of family members:

GMP:

> *"…wherever possible you must avoid providing medical care to yourself or anyone with whom you have a close personal relationship."*

GMC Prescribing and Managing Medicines and Devices:

> *"Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship"*

and further

> *"If you prescribe for yourself or someone close to you, you must:*
>
> *a. make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe.*
>
> *b. tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object."*

368. In his expert report, Dr AC set out the following medical chronology of Dr Tudor's treatment in respect of Patient J:

> *"In the case of the care provided to Patient J Dr Tudor prescribed for a person with a close medical relationship to himself and, in my opinion, there was no necessary reason for Dr Tudor to treat Patient J as he did. Patient J stated in an e-mail to the GMC that Dr Tudor provided care because she was unable to wait two weeks to be seen by her own NHS surgery. Patient J may have believed this to be the case, but, in my opinion, Dr Tudor should not have interpreted this as being a necessary reason to give care directly to Patient J. It is of particular concern that Dr Tudor provided prescriptions for Patient J for anxiety or depression. Dr Tudor's lack of objectivity, consequent upon his close personal relationship with Patient J carried particular risks of inappropriate mental health treatment, and consequent harm, for Patient J. For example, Dr Tudor's did not undertake a suicide risk assessment of Patient J which he should have done when prescribing for her, possibly consequent upon the close personal relationship he had with Patient J. Also, Dr Tudor's prescribing for Patient J included the provision of medications, such as Dovonex Ointment and a Vitamin B12 injection which were for chronic conditions, for which no urgency could reasonably be inferred.*
>
> *Additionally, Dr Tudor did not advise Patient J's NHS surgery of the treatment he had provided for Patient J and the NHS surgery were placed in a position of having to take over care that had been started by Dr Tudor when Patient J attended an appointment on 5th February 2018 with Dr AU, a general practitioner, at the surgery.*
>
> *In my opinion, Dr Tudor did not take account of GMC Guidance when providing care, including prescribing medication, to Patient J XXX. Dr Tudor's actions were seriously*

below the standard expected of a reasonably competent general practitioner. They were seriously below the standard expected because Dr Tudor continued to provide care for Patient J over an extended period, and for conditions which could not plausibly be considered as having any necessary urgency, and doing so placed Patient J at risk of having inappropriate care from a practitioner who could not have assessed and managed her objectively."

369. In his Rule 7 response, Dr Tudor stated that he was aware that it was not appropriate to treat a relative except in certain circumstances. He said that Patient J XXX and that on 8 December 2017, she was unhappy with venlafaxine, a drug which had been prescribed by her NHS GP. Dr Tudor stated that he advised Patient J to stop taking the venlafaxine and he prescribed her 20mg of citalopram once daily, which he increased to 30mg once daily.

370. Dr Tudor stated that he carried out a suicide risk assessment on Patient J and concluded that there was no risk. He said that he left it for Patient J to notify her GP, but that he did not know whether she had done so. Dr Tudor said that he had no intention of treating relatives in the future.

Paragraph 25 of the Allegation

On one or more of the dates set out in Schedule 8 you inappropriately provided the treatment and/or care set out in Schedule 8 to Patient J with whom you had a close personal relationship, in that there was no necessary reason for you to treat Patient J on those occasions. Found proved

371. Dr Tudor accepted that he had treated Patient J, who was a close family relative. The Tribunal was of the view that Dr Tudor should not have been treating Patient J on the 10 occasions set out in Schedule 8, over a period of approximately 18 months, as there was no urgent necessity for her to have received that medical treatment. It was contrary to GMP and the GMC guidance on Prescribing and Managing Medicines and Devices. The Tribunal was satisfied that the consultations as set out in Schedule 8, were reflected in Patient J's medical record as having taken place.

372. The Tribunal therefore found paragraph 25 of the Allegation proved.

Paragraphs 26(a) and (b) of the Allegation

You prescribed for Patient J in relation to anxiety and/or depression but failed to undertake a suicide risk assessment on:

(a) 8 December 2017; Found not proved

(b) 3 January 2018. Found not proved

373. The Tribunal noted Dr Tudor's consultation with Patient J on 8 December 2017 was not even the first consultation he had had with her. That was on 29 November 2017. It considered that this factor made it more difficult for Dr Tudor to justify the contention that it was an urgent consultation.

374. The Tribunal noted that Dr Tudor had prescribed Patient J citalopram 20mg once daily on 8 December 2017, and the dose was increased to 30mg once daily on 3 January 2018. In his Rule 7 response Dr Tudor that he prescribed citalopram on 8 December 2017 because Patient J was unhappy with the venlafaxine that her GP has prescribed her. The Tribunal was therefore satisfied that Dr Tudor had prescribed as set out in the charge.

375. The Tribunal could see no evidence within the medical record on 8 December 2017 of Dr Tudor having carried out a suicide risk assessment. In Patient J's medical note at the subsequent consultation on 3 January 2018, it was recorded that Patient J was having thoughts about death all the time. It was Dr AC's opinion that such matters likely came up in the consultation on 8 December 2017 as well, and that Dr Tudor ought to have undertaken a suicide risk assessment on both occasions. The Tribunal accepted this evidence.

376. The Tribunal also considered that in respect of the consultations Dr Tudor had with Patient J on 8 December 2017 and 3 January 2018, it considered that Patient J being a close family relative could potentially have been a barrier to her being able to have a frank exchange and fully open up about any suicidal thoughts.

377. In relation to both 8 December 2017 and 3 January 2018 however, the Tribunal was not satisfied that the GMC had proven its case, on the balance of probability. Although there was no specific reference to a suicide assessment in the medical notes, there was a note on 3 January 2018 that Patient J was thinking about death all the time. Dr Tudor did record something about her current state of mind at that time, which may have equated to a suicide risk assessment, though he has not used those specific words. There was evidence of Dr Tudor assessing the mental state of the patient. The Tribunal reminded itself that the burden of proof rested with the GMC to prove its case. The absence of a note was not sufficient.

378. The Tribunal therefore found paragraphs 26(a) and (b) of the Allegation not proved.

Paragraph 27 of the Allegation

> You failed to advise Patient J's NHS GP of the treatment you had provided as described at paragraphs 25-26. **Found proved**

379. The Tribunal could see no evidence within Patient J's medical records that Dr Tudor had advised or communicated with Patient J's NHS GP as to the treatment he had provided her. In his Rule 7 response, Dr Tudor stated that he left it up to Patient J to communicate this information and that he did not know whether she had done so or not. The Tribunal treated this as an admission.

380. The Tribunal therefore found paragraph 27 of the Allegation proved.

Patient K

381. In his expert report, Dr AC set out the following medical chronology of Dr Tudor's treatment in respect of Patient K.

> *"At the time of the events of concern Patient K was a 2-year old girl with a history of admission to hospital as an infant with breathing difficulties, but no other significant past medical history. Patient K was XXX of Dr Tudor of Dr Tudor.*
>
> *On* ***3 November 2017*** *Dr Tudor saw Patient K. Dr Tudor's record gives a diagnosis of URTI [Upper Respiratory Tract Infection]/Bronchial Asthma for which a prescription of Erythromycin 250mg/5mls twice daily x 100mls and Phenergan 5mls/5mls at night [unknown quantity] was issued. No other his-tory, examination or management plan was recorded. Subsequently Amoxicillin was issued as an alternative antibiotic due to supply problems from the pharmacy.*
>
> *On* ***7th February 2018*** *Dr Tudor issued Patient K with an inhaler spacer device; no other record was made.*
>
> *On* ***16th October 2018*** *Dr Tudor saw Patient K because of a nocturnal cough and nasal discharge. A family history of asthma and hayfever was noted. Dr Tudor undertook an examination which included an examination of the ears, throat and a chest examination. No general examination or basic physiological assessments were recorded. Dr Tudor diagnosed 'URTI/ Bronchial Asthma' for which a prescription of Co-amoxiclav 125/31 three times daily X 100mls and a Salbutamol inhaler '2 inhalations' twice daily was prescribed. No follow up or safety netting advice was given.*
>
> *On* ***21st November 2018*** *Dr Tudor saw Patient K because of a cough worse at night with a fever a few days before. Dr Tudor undertook an examination which stated 'ENT normal' and a chest examination finding 'medium to low pitched rhonchi, scattered creps.' No general examination or basic physiological assessments were recorded. A diagnosis of bronchial asthma was made and a Salbutamol inhaler 2 inhalations twice daily and Beclomethasone in-haler 50mcg 1 inhalation twice daily was prescribed. No follow up or safety netting advice was recorded.*
>
> *On* ***22nd November 2018*** *Dr Tudor copied the medical records made to date for and sent them to the NHS surgery, apparently at the request of Patient K's mother.*
>
> *On* ***28th November 2018*** *Dr AV, a general practitioner at the NHS surgery, saw Patient K. Dr AV noted that Patient K*

Was issued with SABA [short acting beta agonist – such as Salbutamol] from OOH [Out of Hours] and since then mum has been seeing a private GP (who happens to be [XXX] who has been issuing and has recently started on Clenil.'

Dr AV expressed concern about Dr Tudor providing clinical care for XXX. Dr AV noted improved symptoms since the Beclomethasone inhaler had been started and continued the inhalers prescribed by Dr Tudor.

On 27th June 2019 an entry that was exactly similar to that made on 3rd November 2017 was entered into the records by a third party named 'Patient J'. This is …the mother of Patient K.

On 13th August 2019 Patient J mother of Patient K wrote to the GMC and stated that care was sought from Dr Tudor because of concerns about the management of her care by the NHS surgery and due to difficultly accessing urgent appointments."

382. In his Rule 7 response, Dr Tudor stated that Patient K XXX and that he realised that treating relatives was not appropriate. He said that on 3 November 2017 Patient K's mother asked him to see Patient K as a matter of urgency. He said that he took a history of Patient K's symptoms, namely, a cough that was bad at night but better during the day. A general examination of Patient K revealed that she was not distressed. She was alert and not cyanosed; her heart rate and capillary refill time was normal; and there was no intercostal recession.

383. Dr Tudor said that an examination of Patient K's chest revealed a vesicular breath sound - no added sounds and he diagnosed asthma +/- URTI. He said that he treated Patient K with antibiotics and antihistamines. Dr Tudor stated that on 16 October 2018 Patient K's mother asked him to see Patient K again because of a "*cough which was bad at night but better in the day associated with a wheeze".*

384. Dr Tudor said that an examination of Patient K's chest revealed apyrexial; enlarged tonsilitis and breath sounds were vesicular with no added sounds. He said the diagnosis was asthma +/- URTI. He said she was treated with co-amoxiclav 125mg/5mls TDS and salbutamol 100mcg inhaler 1 puff BD.

385. Dr Tudor stated that on 21 November 2018 he saw Patient K again because of *"a cough and a wheeze 'rattly chest'…".* He said that she was: alert; not distressed; her heart rate and capillary refill time was normal; and she was not pyrexial. He said that an examination of her chest revealed vesicular breath sounds with medium to low pitched rhonchi and scattered crepitations. He said the diagnosis was asthma +/- URTI.

386. Dr Tudor treated Patient K with salbutamol 100mcg inhaler 2 puffs BD and a beclometasone 50 mcg inhaler 1 puff BD, the latter for 'short term use only' because of the risks of inhaled steroids in an infant although she was 3 years old at the time and the risks were minimal. He said that nonetheless he counselled the mother in respect of the benefits

and risks of beclometasone. Dr Tudor stressed that Patient K had been seen by her own GP with her mother with the same symptoms before he became involved in her care as a GP. Dr Tudor refuted the suggestion that he acted below the standard expected of a reasonable competent doctor.

Paragraph 28 of the Allegation

> On one or more of the dates set out in Schedule 9 you inappropriately provided the treatment and/or care set out in Schedule 9 to Patient K with whom you had a close personal relationship, in that there was no necessary reason for you to treat Patient K on those occasions. Found proved

387. Dr Tudor accepted and acknowledged that Patient K was a close family relative and that he had been treating her. He accepted treating relatives was not appropriate but that on the occasion of 3 November 2017, he was asked by Patient K's mother to see Patient K as a matter of urgency. The Tribunal noted that Dr Tudor did not expressly say as to why the consultation was urgent, nor for that matter the further consultations as set out at Schedule 9. The Tribunal was satisfied that all these consultations had taken place and were not justified as stated by Dr Tudor.

388. Dr AC alluded to an email from Patient K's mother to the GMC regarding difficulty accessing care for Patient K with her NHS GP:

> *"Patient J (Mother of Patient K) stated in an e-mail to the GMC that Dr Tudor provided care because of difficulty accessing care at Patient K's NHS surgery, partly because of a dispute over the management of Patient K by their NHS surgery. Patient J may have believed there were difficulties accessing care, and had good reasons to dispute the care provided by the NHS surgery; but, in my opinion, Dr Tudor should not have interpreted this as being a necessary reason to give care directly to Patient K. It is likely that if Patient K had presented to an NHS surgery with respiratory symptoms as described by Dr Tudor that they would have been seen a timely manner."*

389. The Tribunal accepted and relied on the opinion of Dr AC. Furthermore, on 3 November 2017 the chemist was unable to supply erythromycin and Dr Tudor wrote another prescription the next day, so Patient K's mother, in the Tribunal's view, could not have been so worried that it required an urgent consultation with Dr Tudor.

390. The Tribunal again considered that Dr Tudor's actions were contrary to GMP and the GMC guidance on Prescribing and Managing Medicines and Devices, as there was no necessary reason for him to treat Patient K on one or more of those occasions as set out in Schedule 9.

391. GMP states that when treating a close relative a doctor

> *"you must:*

a. make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe."

392. The Tribunal could see no note in the Patient K's medical record as to Dr Tudor's relationship with Patient K, nor the reason it was necessary for him to prescribe.

393. The Tribunal therefore found paragraph 28 of the Allegation proved.

Paragraph 29 of the Allegation

Between 3 November 2017 and 22 November 2018 you failed to advise Patient K's NHS GP of the treatment you had provided as described at paragraph 28. **Found proved**

394. The Tribunal could see no record within medical notes that there had been any communication from Dr Tudor with Patient K's NHS GP in respect of paragraph 28. The first communication it could see was a letter on 22 November 2018 in which Dr Tudor stated:

"I have been requested by [Patient J] to provide details of my involvement in [Patient K's] medical care at Tudor Medical Matters for the reference of her NHS GP and also to update her medical records. I have seen [Patient K] on a number of occasions over the past year, an include her session notes for your information…"

395. Dr Tudor included in his letter his session notes from all the consultations he had had with Patient K between 3 November 2017 to 21 November 2019. It appeared that Dr Tudor was updating Patient K's NHS GP with about a years' worth of consultations in one go. It determined that as set out, Dr Tudor had failed to inform Patient K's NHS GP of the treatment he had provided Patient K, as described at paragraph 28, between 3 November 2017 and 22 November 2018.

396. The Tribunal therefore found paragraph 29 of the Allegation proved.

Paragraphs 30(a)-(c) of the Allegation

On 3 November 2017 you consulted with Patient K and failed to:

(a) take any history from Patient K's parent; **Found not proved**

(b) carry out an adequate examination in that you did not undertake:

(i) a general examination to determine:

(1) Patient K's overall appearance;
Found not proved

(2) whether Patient K was alert;
Found not proved

(3) whether Patient K was distressed;
Found not proved

(ii) any basic physiological observations;
Found not proved

(iii) an examination of Patient K's chest;
Found not proved

(c) obtain informed consent from Patient K's parent in that you did not provide Patient K's parent with:

(i) advice on the possible side effects of the medication you prescribed; **Found not proved**

(ii) safety netting advice; **Found not proved**

397. In respect of paragraph 30(a), the Tribunal considered that it seemed unlikely that Dr Tudor did not take some history from Patient K's mother. Given his close family relationship with both Patient J and Patient K, the Tribunal was satisfied that Dr Tudor would have taken some history. He was an experienced GP treating his XXX.

398. Dr Tudor noted the cause of Patient K's symptoms as bronchial asthma in his Rule 7 response. The Tribunal also observed that in his Rule 7 response, Dr Tudor had set out a significant amount of history that was not recorded in Patient K's medical notes. The Tribunal accepted Mr Morwood's submission that this appeared to be a surprisingly good recollection of a consultation in respect of which Dr Tudor had made almost no notes. The Tribunal was cautious about placing full reliance on this account. It was of the view that, given Patient K was a close family relative, it was likely he would have taken at least some history, and that he would have known some history already. The Tribunal determined that the GMC had not proven its case.

399. In respect of paragraphs 30(b)(i), (ii) and (iii), the Tribunal bore in mind that the burden of proof was on the GMC to prove its case and Dr Tudor did not have to prove anything. The Tribunal was satisfied that, as it has set out above in relation to paragraph 30(a), Dr Tudor's consultation must have involved more than the medical record suggests and, that on the balance of probabilities, it included that matters set out at paragraphs 30(b)(i), (ii) and (iii). The Tribunal determined that for the same reasons as set out at paragraph 30(a) the GMC had not proven its case.

400. In respect of paragraphs 30(c)(i) and (ii), the Tribunal determined that, for the same reasons as set out above in respect of paragraphs 30(a) and (b), the GMC had not proven its case.

401. The Tribunal therefore found paragraphs 30(a), (b) and (c) of the Allegation not proved.

Paragraphs 30(d)-(e) of the Allegation

On 3 November 2017 you consulted with Patient K and failed to:

(d) prescribe appropriately in that you prescribed the following medication when it was not clinically indicated:

(i) Phenergan; **Found not proved**

(ii) Erythromycin; **Found not proved**

(e) make a record of having undertaken the actions referred to at paragraph 30a-c. **Found proved**

402. In respect of paragraph 30d, the Tribunal had noted the expert report of Dr AC, in which he stated:

> *"At the consultation on **3rd November 2017** Dr Tudor prescribed Phenergan for Patient K. This medication can be prescribed for various symptoms, including nasal congestion and wheeze, but Dr Tudor's record does not give any rationale for his prescription. Dr Tudor also prescribed Erythromycin (and the Amoxicillin), which is a powerful antibiotic. Dr Tudor's history and examination of Patient K did not support the prescription of an antibiotic, which would generally be given for a significant bacterial infection. If Dr Tudor suspected that there was a significant bacterial infection then he did not undertake an examination that included general observations and general physiological assessments… In my opinion Dr Tudor treated Patient K with Phenergan and Erythromycin (and then Amoxicillin) when there was no indication to do so, and the antibiotic selected was particularly likely to cause her side effects. In my opinion Dr Tudor's actions in prescribing both Phenergan and Erythromycin (and then Amoxicillin) to Patient K were without justification, not consistent with GMC Good Medical Practice and seriously below the standard expected of a reasonably competent general practitioner. Dr Tudor's actions were seriously below the standard expected because his prescribing placed Patient K at risk of coming to harm from medication which she did not need to take."*

403. The Tribunal echoed the opinion of Dr AC that it could not see a rationale recorded as to why Dr Tudor prescribed Phenergan and erythromycin. It found that Phenergan was used

for symptoms including nasal congestion and wheeze, and that erythromycin is an antibiotic which would generally be given for a significant bacterial infection.

404. The Tribunal was satisfied that the reported symptoms of Patient K potentially indicated the use of a nasal decongestant. It agreed that the rationale had not been set out in the medical records. However, the Tribunal took the view that it had been prescribed to address some of the symptoms referred to in the notes, and that it was appropriate to do so. The GMC had certainly not established that this prescription was inappropriate.

405. In respect of the erythromycin, it was the GMC's case that if Dr Tudor diagnosed, or suspected a bacterial infection, he would have needed to have undertaken an examination and recorded his findings and his rationale for prescribing, but that there was no such information and that it was not therefore clinically indicated.

406. Dr Tudor was treating a close family relative, the Tribunal considered it unlikely, on the balance of probabilities, that he would been prescribing these medications if they were not clinically indicated or if he had no rationale for prescribing them.

407. The Tribunal appreciated the criticisms of Dr AC and agreed with him in that it could see no rationale or reasoning for Dr Tudor's prescriptions of erythromycin. Nonetheless, the Tribunal was satisfied that it could safely infer that Dr Tudor prescribed the antibiotic as he had identified a bacterial infection in a close family relative. The Tribunal recognised that there was criticism aimed at Dr Tudor's record keeping, but it was of the view that was a separate matter. The Tribunal determined therefore that, in respect of erythromycin, the charge was not made out. There may well have been other treatments available. These may have been preferred by other practitioners in the circumstances. This did not make Dr Tudor's prescription inappropriate.

408. In respect of paragraph 30(e), the Tribunal was satisfied that Dr Tudor's record keeping was well short of what was to be expected, especially when compared to his extensive note in his Rule 7 response. The Tribunal were of the view that if Dr Tudor had done all that he has stated in his Rule 7 response, then his original contemporaneous record in Patient K's medical notes should have reflected that amount of detail. The Tribunal determined therefore, consistent with similar findings as to Dr Tudor's record keeping, that this paragraph was made out.

409. The Tribunal therefore found paragraphs 30(d)(i) and (ii) not proved and paragraph 30(e) of the Allegation proved.

<u>Paragraphs 31(a)-(d) of the Allegation</u>

On 16 October 2018 you consulted with Patient K and failed to:

(a) carry out an adequate examination in that you did not undertake:

(i) a general examination to determine:

(1) Patient K's overall appearance; **Found not proved**

(2) whether Patient K was alert; **Found not proved**

(3) whether Patient K was distressed; **Found not proved**

(ii) any basic physiological observations; **Found not proved**

(b) obtain informed consent from Patient K's parent in that you did not provide Patient K's parent with:

(i) advice on the possible side effects of the medication you prescribed; **Found not proved**

(ii) safety netting advice; **Found not proved**

(c) prescribe appropriately in that you prescribed Co-amoxiclav when it was not clinically indicated; **Found not proved**

(d) make a record of having undertaken the actions referred to at paragraph 31a-b. **Found proved**

410. In respect of paragraph 31(a), the Tribunal noted that there were some observations made by Dr Tudor in respect of Patient K. In the medical record Dr Tudor recorded: a *"Cough worse at night wheeze fractious and nasal discharge…Exam ears normal … enlarged tonsils BS Vesicular no added sounds"*.

411. The Tribunal compared Dr Tudor's medical record to that of the NHS GP medical record of the consultations either side of the one Dr Tudor had with Patient K on 16 October 2018.

412. On 10 October 2018, the NHS GP medical record stated:

"Problem	***Eczema NOS** (First)*
History	*normally has dry skin, mum uses lotions and creams to support skin flare up of eczema to the ankle and folds in elbow*
	red
	dry
	itcy
Examination	*eczema*
	erythema

Medication	*Cetraben cream (Thornton & Ross Ltd) use instead of soap in shower* *500 gram Hydrocortisone 1 % cream Apply Thinly Twice A Day As Directed 30 gram*
Comment	*treat as px* *rvw worsen or concerned* *adv red flags and safety netting* *Discussion about clinical red flag warning signs* *Advice regarding provision of local health service* *Reassurance given"*

413. On 25 October 2018, the NHS GP medical record stated:

"Problem	***Upper respiratory** tract **Infection NOS** (First)*
History	*ongoing wheeze but seen y paeds - on montelukast and salbutamol 1 puff bd* *last few days cough and high temp runny nose* *sl off food*
Examination	*alert smiling* *t36.3* *ent nad apart from clear nasal mucus* *pulse 80* *rr 16* *chets bilat exp wheeze and fine creps* *no recession*
Comment	*viral* *advised try inc salbutamol 3-4 puffs qds prn* *calpol and(sic) fluids* *see if(sic) deteriorates"*

414. The Tribunal considered that the NHS GP medical record were significantly better than Dr Tudor's medical records, they provided more information and referred to red flags and discussion about safety netting, and recorded the advice given to Patient K's mother. Whilst Dr Tudor had made some observations, his notes were not a full as they could be. However, the notes that he did make suggested an examination had taken place.

415. In his Rule 7 response Dr Tudor specifically stated that he had carried out a general examination to determine Patient K's overall appearance; whether Patient K was alert; whether Patient K was distressed; and any basic physiological observations.

416. The Tribunal was of the view that there was a suggestion in Dr Tudor's medical record of an examination, albeit the note was poor and lacking in specifics. It determined that on that basis, and as Dr Tudor did not need to prove anything, the GMC had not proven its case in respect of paragraph 31(a).

417. In respect of paragraphs 31(b)(i) and (ii), the Tribunal was of the view that the exclusion of a note did not necessarily mean that consent was not obtained from the parents. For this reason and those given in respect of similar allegations in this determination, the Tribunal determined that the GMC had not proven its case. The Tribunal were mindful in this case that the parent was XXX, and the patient XXX.

418. In respect of paragraph 31(c), the Tribunal found that the GMC had not proven its case. As already stated, there was evidence of a significant infection, which justified the prescription of antibiotics. In this context, Dr Tudor's prescription of co-amoxiclav was likely to be clinically indicated.

419. In respect of paragraph 31(d), Dr Tudor failed to make an appropriate record of having undertaken the actions referred to at paragraphs 31(a)-(b).

420. The Tribunal therefore found paragraphs 31(a)(i)(1), (2) and (3), 3(1)(a)(ii), 31(b)(i) and (ii), and 31(c) not proved, and paragraph 31(d) of the Allegation proved.

Paragraphs 32(a)-(c) of the Allegation

On 21 November 2018 you consulted with Patient K and failed to:

(a) carry out an adequate examination in that you did not undertake:

(i) a general examination to determine:

(1) Patient K's overall appearance; **Found not proved**

(2) whether Patient K was alert; **Found not proved**

(3) whether Patient K was distressed;
Found not proved

(ii) any basic physiological observations; **Found not proved**

(b) obtain informed consent from Patient K's parent and that you did not provide Patient K's parent with:

(i) advice on the possible side effects of the medication prescribed; **Found not proved**

(ii) safety netting advice; **Found not proved**

(c) make a record of having undertaken the actions referred to at paragraph 32a-b. **Found proved**

421. The Tribunal determined that for the same reasons as already set out in respect of paragraph 31 of the Allegation, it found paragraphs 32(a)(i)(1), (2) and (3), and 32(a)(ii), 32(b)(i) and (ii), not proved, and paragraph 32(c) of the Allegation proved.

General clinical concerns

Patient L

422. The Tribunal made the following findings. Patient L was a 31 week old child. She was born at term after an uneventful pregnancy and had no significant past medical history. On 28 December 2017 Dr AW, a GP from Patient L's NHS surgery, saw Patient L with symptoms suggestive of a respiratory tract infection. A diagnosis of bronchiolitis was made.

423. Between 8 January 2018 and 16 February 2018 various NHS GPs saw Patient L with ongoing symptoms of wheezing. On 16 February 2018 Dr AM prescribed a salbutamol inhaler as treatment for the ongoing wheeze. On 8 March 2018 Dr Tudor saw Patient L and undertook a history that was recorded as:

> *"3-month history of cough and wheeze worse at night and in the morning. Wakes at 4am with a cough, difficulty breathing and posseting, sometimes projectile mouth breaths. Been to GP several times. Parents told has bronchiolitis. Family History – Maternal Grandmother has asthma and rhinitis, Paternal grandfather has asthma, mother and father not affected. Gaining weight."*

424. Dr Tudor undertook an examination that was recorded as:

> *"ENT normal apart from rhinitis. [Breath Sounds] vesicular with scattered medium to high pitched rhonchi [sic]"*

425. Dr Tudor made a diagnosis of bronchial asthma and formulated a treatment plan for:

> *"Beclometasone [inhaler] 50mcg [twice daily], Salbutamol spray 100mcg [four times daily] (both via nebulizer) [and] Co-amoxiclav 125/31 [in 5mls, three times daily] x100mls"*

426. Dr Tudor advised that Patient L should be seen in one week and requested that Patient L's NHS GPs continue to prescribe beclometasone and salbutamol inhalers as necessary. No explicit safety netting advice was recorded. Dr Tudor's consultation record was forwarded to the NHS surgery and incorporated into their record on 29 March 2019.

427. On 14 March 2018 Dr Tudor saw Patient L and his record stated that she was much better with reduced wheeze. An examination of her chest was undertaken that was normal and advice was given to continue her inhalers with a planned review in 4 weeks' time. Dr Tudor's consultation record was forwarded to the NHS surgery and incorporated into their record on 29 March 2019.

428. In his Rule 7 response, Dr Tudor stated that Patient L presented with a 3 month history, a cough and a wheeze that was worse at night than in the morning. He said that Patient L reported that most nights she would wake up with a cough associated with projectile vomiting. He stated that Patient L had seen her GP on numerous occasions, her parents we not satisfied with their GP and that why she was brought to see him.

429. Dr Tudor stated that there was a strong family history of asthma, and that he carried out a full medical examination. He stated that Patient L was apyrexial, her temperature as normal and there was evidence of rhinitis. He said that the breath sound was vesicular with scattered medium to high pitched rhonchi (which was indicative of bronchospasm).

430. Dr Tudor stated that in light of the family history and examination findings, he made the diagnosis of bronchial asthma. He stated that this was a reasonable diagnosis in the circumstances. He stated that he prescribed a salbutamol and a beclometasone inhaler, and he counselled Patient L's parents regarding the beclometasone, which was not intended to be long term because of the potential risks in an infant. Dr Tudor stated that he prescribed the smallest dose possible to minimise any risk and, he also prescribed co-amoxiclav to combat any possibility of infection.

431. Dr Tudor stated that Patient L was much better the following week and was completely symptom free on 11 April 2018 and so he reduced beclometasone to 50mcg once daily. He said that on 30 May 2018 he issued a prescription for salbutamol 100 mcg inhaler to use as required and that he stopped the beclometasone. Dr Tudor stated that he also sent a copy of his session notes to Patient L's GP for information purposes.

Paragraphs 33(a)-(d) of the Allegation

On 8 March 2018 you consulted with Patient L and you failed to:

(a) carry out an adequate examination in that you did not undertake:

(i) a general examination to determine:

(1) her overall appearance: **Found not proved**

(2) whether she was alert: **Found not proved**

(3) whether she was distressed; **Found not proved**

(ii) basic physiological observations of Patient L's:

(1) heart rate; **Found not proved**

(2) respiratory rate; **Found not proved**

(3) capillary refill time; **Found not proved**

(4) oxygen saturation; **Found not proved**

(b) prescribe appropriately in that you prescribed:

(i) Co-amoxiclav when it was not clinically indicated; **Found not proved**

(c) obtain informed consent from Patient L's parents:

(i) for the prescription of Co-amoxiclav in that you did not provide Patient L's parents with:

(1) advice on the potential side effects of the medication; **Found not proved**

(2) safety netting advice; **Found not proved**

(ii) for the prescription of a Beclometasone inhaler in that you did not inform Patient L's parents that the prescription was:

(1) outside of the licenced indication of the medication; **Found not proved**

(2) inconsistent with relevant guidance; **Found not proved**

(d) make a record of having undertaken the actions referred to at paragraph:

(i) 33a; **Found proved**
(ii) 33c. **Found proved**

432. In respect of paragraphs 33(a), the Tribunal was of the view that there was some evidence of an examination, albeit that Dr Tudor's record keeping seemed poor. It determined that the GMC had not proven its case, for the same reasons as those relied upon in respect of paragraph 2(b) of the Allegation. In short, the absence of an adequate record of an event did not necessarily mean that it did not happen.

433. In respect of paragraph 33(b), Dr Tudor noted that Patient L presented with a 3 month history, a cough and a wheeze that was worse at night than in the morning. He said that Patient L's parent reported that most nights she would wake up with a cough associated with projectile vomiting. The Tribunal noted that there were persistent symptoms.

434. The Tribunal found that in the NICE guidelines on Asthma, revised April 2018, it stated:

"For children under the age of five years with suspected asthma:

- *Offer an eight week trial of a paediatric moderate dose of ICS [inhaled corticosteroid] if there are symptoms that clearly indicate the need for maintenance therapy (occurring 3 times a week or more, or causing waking at night, or uncontrolled with a SABA [short-acting beta-2 antagonist] alone). After 8 weeks, stop ICS treatment and continue to monitor the child's symptoms. If symptoms did not resolve during the testing period, consider an alternative diagnosis… If symptoms resolved then reoccurred within 4 weeks of stopping ICS treatment, restart the ICS at a paediatric low dose as first-line management therapy. If the symptoms resolved but reoccurred beyond 4 weeks after stopping ICS treatment, repeat the 8-week trial to a paediatric moderate dose of ICS.*
- *If suspected asthma is uncontrolled is children under 5 on paediatric low dose of ICS as a maintenance therapy, consider an LRTA [leukotriene receptor antagonist] in addition to the ICS.*
- *If suspected asthma is uncontrolled is children under 5 on paediatric low dose of ICS and an LRTA a maintenance therapy, stop the LRTA and refer the child to a healthcare professional with expertise in asthma for further investigation and management.*
- *Note: The evidence for treatment safety and efficacy is less clear for children under the age of two years than for other age groups, and the threshold for seeking specialist opinion should, therefore be lowest in this group…."*

435. Dr AC opined that Dr Tudor's prescription of beclometasone was not licenced in children as young as Patient L because they were outside the age range of a clinical trial. He conceded however that that such treatment was prescribed regularly for minors. He did not agree with Dr Tudor's use of beclometasone and said that Dr Tudor would have needed a good reason to have used beclometasone outside of license and to have recorded that reasoning. The Tribunal was satisfied that the GMC has not proven its case the light of concessions made by Dr AC in his oral evidence in respect of the prescribing of beclometasone.

436. The Tribunal was satisfied that there were symptoms here which were consistent with, amongst other things, asthma and a serious bacterial infection. The Tribunal determined that prescribing Patient L's antibiotics in the form of co-amoxiclav was therefore clinically indicated in the circumstances of this case.

437. In respect of paragraph 33(c), again the Tribunal determined that for reasons already expressed in this decision, that the absence of a note in the medical record did not mean that informed consent was not obtained in respect of the prescription of co-amoxiclav and beclometasone. It was determined that the GMC had not discharged the burden of proof.

438. In respect of paragraph 33(d), the Tribunal noted that there was an inadequate record of the matters mentioned in paragraphs 33(a) and 33(c) and that the charge was therefore made out.

439. The Tribunal therefore found paragraphs 33(a)(i)(1), (2) and (3), 33(a)(ii)(1), (2), (3) and (4), 33(b)(i), 33(c)(i)(1) and (2), and 33(c)(ii)(1) and (2) not proved, and paragraph 33(d)(i) and (ii) of the Allegation proved.

Patient M

440. At the time of the events of concern Patient M was a 26 year old man with a history of bipolar disorder. Dr Tudor himself provided a chronology of the care he gave to Patient M in a Significant Event Report dated 24 July 2018. Dr Tudor saw this patient while working at PMM. On 29 May 2018 Patient M stated that he had just moved from Gravesend to Blackpool, and that he had not as yet registered with a NHS GP. He had been taking:

Zopiclone 7.5 mg Nocte
Codeine 30 mg 2 tablets
Oxazepam 10 mg 2 TDS
Citalopram 20 mg OD.

441. The record shows that Dr Tudor prescribed 7 days supply of zopiclone, codeine and oxazepam and 30 days supply of citalopram. On 4 June 2018, i.e. less than 1 week later Patient M returned. On this occasion he was prescribed a 30 days supply of all 4 medications again. On 11 June 2018 he returned and told Dr Tudor that his partner had inadvertently put his medication in the washing machine on a full cycle. He had as evidence a bag of washed out tablets and packets bearing the name of the medication prescribed previously. Satisfied that his medications were water damaged, Dr Tudor issued him with another prescription.

442. Later the same day a pharmacist contacted PMM but did not speak to Dr Tudor. In addition, the pharmacist reported this prescription to NHS England. On 19 June 2018 Dr Tudor had an in depth telephone conversation with Mr AX, a professional advisor for NHS England. He explained the sequence of events to him.

443. On 19 June 2018 Patient M made another appointment to see Dr Tudor. Dr Tudor told him that he was an addict and that he needed help in respect of this. He prescribed another 7 days supply of his medications. On 25 June 2018 he came back but was refused treatment.

444. In his Rule 7 response, Dr Tudor stated that he first saw Patient M at Pall Mall Medical on 29 May 2018, that Patient M had recently moved to Blackpool and was not yet registered with a GP. He noted that Patient M was never a patient at TMM.

445. Dr Tudor said that Patient M reported to him that he was suffering from psychosis, bipolar disorder and required a repeat prescription for his usual medication namely zopiclone 7.5mg, codeine 30mg, oxazepam 10mg and citalopram. Dr Tudor said that he had no other information available to him to confirm that this was his ongoing prescription. He said that he provided a 7 days supply of treatment.

Paragraphs 34(a)-(d) of the Allegation

> On 29 May 2018 you consulted with Patient M and inappropriately prescribed one or more of the medications set out in Schedule 10 in that you:
>
> (a) prescribed the medication when it was not clinically indicated; **Found proved**
>
> (b) failed to obtain any confirmatory evidence for Patient M's ongoing prescription; **Found proved**
>
> (c) failed to obtain any details of the psychiatric care Patient M may have been receiving; **Found proved**
>
> (d) prescribed the medication in excessive quantities. **Found not proved**
>
> Schedule 10
>
> Oxazepam 10mg x 42
> Zopiclone 7.5mg x 7
> Codeine 30mg x 56

446. The Tribunal concluded that Dr Tudor did not prescribe appropriately in this instance. On 29 May 2018, he took a history of Patient M requiring a repeat prescription for several medications including oxazepam, zopiclone and codeine. Dr Tudor's history identified that Patient M suffered from bipolar disorder. Dr Tudor did not obtain any confirmatory evidence for Patient M's ongoing prescription, such as a previous prescription from an NHS GP. Nor did he obtain any details of psychiatric care that Patient M might have been undertaking. This was outside of the guidance for these medications.

447. The Tribunal went on to the find that of the medications prescribed only citalopram would be indicated for bipolar disorder, and only if Patient M was depressed. This would be a situation where caution would be advised as citalopram should not be used for a patient in, or at risk of, mania.

448. The other medications did not have any recognisable indication for use: oxazepam is indicated for short term treatment of anxiety; zopiclone is a hypnotic; and codeine is an opiate painkiller. There was no clinical indication for oxazepam, zopiclone or codeine.

449. In respect of paragraph 34(b), Dr Tudor failed to obtain any confirmatory evidence for Patient M's ongoing prescription. The Tribunal had regard to the NICE guidelines for 'Controlled drugs: safe use and management'. In the guidance it sets out that a GP must make himself aware of any ongoing medication the patient is receiving from other GPs. Patient M must have received his previous prescriptions from somewhere and Dr Tudor had an obligation to ask Patient M where he got them from previously. He failed to do this. Furthermore, as a private GP, if Dr Tudor was unsure, he had no obligation to treat Patient M. The Tribunal was therefore satisfied that Dr Tudor had failed to obtain any confirmatory evidence for Patient M's ongoing prescription.

450. In respect of paragraph 34(c), Dr Tudor failed to obtain any details of the psychiatric care Patient M may have been receiving. The Tribunal could see no evidence of a conversation to this effect. There was no evidence to refute this allegation and Dr Tudor in his Rule 7 response did not address it. The Tribunal was satisfied therefore that the allegation was made out.

451. In respect of paragraph 34(d), the Tribunal considered the allegation that Dr Tudor prescribed the medication in excessive quantities on 29 May 2018. Dr AC accepted that his concerns were based around the regularity of medication and the number of prescriptions issued by Dr Tudor to Patient M over the period Dr Tudor treated Patient M. Dr AC accepted that his concern was not specifically based on the one prescription issued on 29 May 2018 which formed the basis of head of charge 34.

452. Dr AC accepted that in relation to the prescription issued on 29 May 2018 specifically, the dosage quantities on that occasion were not outside the specified amount in the BNF.

Patient N

453. The Tribunal found that Patient N was a 50 year old woman with a history of chronic fatigue/fibromyalgia, and of pulmonary embolism. She had complex neurological symptoms and was taking Aspirin 300mg daily after investigation for a possible transient ischaemic attack (TIA) in January 2020. Patient N had had mildly deranged APTT for some years as assessed during attendance at accident and emergency; her clotting screen was otherwise normal and no diagnosis of a hypercoagulable state, such as antiphospholipid syndrome had been made.

454. On 25 March 2020 Mr AY, a private general practitioner working at Dr Tudor's private practice saw Patient N and took a history of various neurological symptoms and a history of thromboembolism and multiple miscarriage. Patient N was concerned that she has antiphospholipid syndrome. Mr AY arranged for blood tests to be undertaken.

455. On 13 May 2020 Dr Tudor undertook a telephone consultation with Patient N in which he discussed various symptoms and a history of a possible cerebrovascular disease. Dr Tudor advised blood tests be undertaken. These included:

TSH 3.81 mu/l	(Range 0.27-4.2)
T4 12.9 pmol/l	(Range 12-22)
APPT 21 sec	(Range 25-37 – clotting screen otherwise normal)

456. On 14 May 2020 Dr Tudor saw Patient N with multiple symptoms including fatigue and a history of previous thromboembolism. Dr Tudor diagnosed antiphospholipid syndrome and prescribed clopidogrel 75mcg daily in addition to her aspirin 300mg daily. On 18 May 2020 Dr Tudor undertook a telephone consultation with Patient N where it was stated her symptoms in general have improved since she has been on clopidogrel.

457. On 25 May 2020 Dr AZ a neurologist undertook a telephone consultation with Patient N and arranged for a brain scan and further blood tests to be performed. On 10 June 2020 Dr Tudor made a referral to an unnamed private haematologist to review Patient N's case. Also, Dr RP, a GP at Patient N's NHS surgery undertook a telephone consultation where Dr Tudor's recent treatment was discussed along with a request for an NHS prescription of an anticoagulant drug which was declined.

458. On 12 June 2020 Dr AZ a neurologist wrote to the NHS surgery after reviewing Patient N's investigations including brain scans and an extensive range of blood tests, including antiphospholipid antibodies and stated they were largely reassuring. Dr AZ did not make a diagnosis of antiphospholipid syndrome. Also, Ms BA, practice manager at Patient N's NHS surgery wrote an email to the GMC raising concerns about Dr Tudor's diagnosis of antiphospholipid syndrome.

459. On 23 June 2020 Mr AA, a private general practitioner saw Patient N and referred to ongoing use of clopidogrel and frustration on the part of Patient N due to her underlying diagnosis still not being clear. On 24 June 2020 Dr BB, a haematologist, undertook a video consultation with Patient N and reviewed her case. Dr BB concluded that Patient BB's coagulation screen was normal and did not diagnose antiphospholipid syndrome. Dr BB advised further blood tests and an NHS haematology review.

460. In his Rule 7 response, Dr Tudor stated that Patient N presented with a 3 month history of intermittent weekly episodes of slurred speech associated with left leg weakness and was admitted to hospital and underwent an MRI brain scan which was normal, and she was put on aspirin. He stated that when the aspirin was stopped when Patient N was discharged from hospital. He said a CT scan of her head was also normal.

461. Dr Tudor stated that when Patient N had further symptoms, she self-medicated with aspirin which helped. He said that her GP told her that aspirins were a placebo. Dr Tudor said that in her medical notes he recorded that Patient N had had four miscarriages and DVT/PE (deep vein thrombosis/ pulmonary embolism). He said that antiphospholipid syndrome tests

at the time were uninformative, and two months later Patient N was readmitted to hospital with TIA/CVA symptoms. Investigations into this turned out to be normal.

462. Dr Tudor stated that additionally, Patient N subsequently developed autoimmune symptoms notable abdominal pain bloating and wind (possible Chron's disease) and depigmentation of her skin (Vitiligo). In addition to brain fog, Dr Tudor stated that Patient N suffered cold hands and feet and dry hair which was possibly hypothyroidism. He noted that her maternal cousin may have had similar problems. He said that he felt antiphospholipid syndrome was the likely diagnosis.

463. Dr Tudor stated that Patient N's thyroid function was abnormal at TSH 3.81 and T4 12.9 and he referred her to a consultant haematologist. Additionally, he prescribed her clopidogrel 75mg once daily pending her appointment with the consultant haematologist. He said that he obtained Patient N's informed consent regarding his decision to prescribe clopidogrel which was contrary to relevant medical advice and as to the potential for her to experience serious side effects.

464. Dr Tudor stated that he sent copies of his session notes to Patient N's GP and that he believed his actions were those of a competent doctor and were, above all, in the best interests of the patient.

Paragraphs 35(a)-(c) of the Allegation

On 14 May 2020 you consulted with Patient N and you failed to:

(a) prescribe appropriately in that you prescribed Clopidogrel 75mg daily for anti-phospholipid syndrome:

(i) when her condition had not been considered by an appropriately qualified specialist; Found proved

(ii) in addition to an ongoing prescription of aspirin 300mg daily; Found proved

(b) obtain informed consent from Patient N in that you did not advise Patient N that:

(i) the decision to prescribe Clopidogrel was contrary to relevant guidance; Found not proved

(ii) of the potential for Patient N to experience serious side-effects; Found not proved

(c) make a record of having undertaken the actions refer to at paragraph 35b. Found proved

465. In respect of paragraph 35(a), the Tribunal found that Dr Tudor did not prescribe appropriately for Patient N because on 14 May 2020 he gave her treatment for anti-phospholipid syndrome with clopidogrel 75mcg daily when her condition had not been considered by an appropriately qualified specialist. Further, that the addition of clopidogrel to an ongoing prescription of Aspirin 300mg daily (dual antiplatelet therapy) was not appropriate for antiphospholipid syndrome. The Tribunal had regard to the *British Journal of Haematology: Guidelines on the investigation and management of antiphospholipid syndrome, published 8 February 2012; David Keeling, Ian Mackie, Gary W. P, Ian A. Greer, Michael Greaves, British Committee for Standards in Haematology*, in which it set out that using dual anti-platelet drugs was not appropriate.

466. Patient N was left at significant risk of side effects from the prescription of clopidogrel along with aspirin and, additionally, left at risk of not having further investigations and/or a referral for an appropriate specialist opinion to determine her optimal treatment. By prescribing clopidogrel for Patient N when this was not indicated Dr Tudor was acting outside of his competency as a general practitioner. Dr Tudor's prescribing of clopidogrel was not consistent with relevant guidance and was inconsistent with GMP.

467. Dr Tudor's referral to a consultant haematologist did not take place until 10 June 2020, about four weeks after the original diagnosis and prescription. There was a complex clinical picture and Dr Tudor had already made a working diagnosis and had been treating Patient N for anti-phospholipid syndrome with clopidogrel 75mg daily for a significant period prior to referral. Furthermore, the diagnosis was inappropriate in that the blood test results were not indicative.

468. Following the referral, the consultant haematologist sent Dr Tudor a letter dated 24 June 2020, in which it stated:

> *"Given her recurrent symptoms and laboratory tests I can assure you this lady does not have any features suggesting anti-phospholipid syndrome …."*

It is a remarkable aspect of this part of the case that this does not appear to have altered Dr Tudor's approach to this patient.

469. In respect of paragraph 35(b), the Tribunal considered whether Dr Tudor failed to obtain informed consent from Patient N in that he did not advise Patient N that the decision to prescribe clopidogrel was contrary to relevant guidance and of the potential for Patient N to experience serious side-effects.

470. For the same reasons as set out in respect of similar allegations, the Tribunal considered that whilst there was no note in the medical record that Dr Tudor did obtain informed consent. The burden rests with the GMC and the Tribunal was not satisfied that the GMC had discharged that burden. Of course, the Tribunal was satisfied that the record keeping of such a process was far from adequate.

471. The Tribunal therefore found paragraphs 35(a)(i) and (ii), and 35(c) proved, and paragraph 34(b)(i) and (ii) of the Allegation not proved.

The Tribunal's Overall Determination on the Facts

472. The Tribunal has determined the facts as follows:

Hypothyroidism Patients

Patient A

1. On 2 August 2017 you consulted with Patient A and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient A's blood results indicating a normal thyroid function. **Found proved**

2. On one or more of the dates set out in Schedule 1 you failed to:

    a. prescribe appropriately in that you prescribed Levothyroxine for Patient A when it was not clinically indicated; **Found proved**

    b. obtain informed consent from Patient A in that you did not advise Patient A:

        i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

        ii. of the potential for Patient A to experience serious side effects; **Found not proved**

    c. make a record of having undertaken the actions referred to at paragraph 2b. **Found proved**

3. On one or more of the dates set out in Schedule 2 you failed to:

    a. prescribe appropriately in that you prescribed Methotrexate for Patient A when:

        i. it was not appropriate for you to do so without input from an appropriately qualified specialist; **Found proved**

        ii. Patient A had not been diagnosed with:

            1. rheumatoid arthritis; **Found proved**

2. psoriatic arthritis; **Found proved**

iii. you prescribed a higher dose than advised in the British National Formulary ('BNF') guidance; **Found not proved**

iv. you did not:

1. also prescribe folic acid to limit the side effects of Methotrexate; **Found proved**

2. arrange for Patient A to be monitored before initiation of Methotrexate; **Found proved**

3. put a plan in place for Patient A to be monitored on a weekly/fortnightly basis after initiation of Methotrexate; **Found proved**

4. advise Patient A's NHS General Practitioner ('GP') of the prescription; **Found not proved**

b. obtain informed consent from Patient A in that you did not adequately counsel Patient A on the use of Methotrexate; **Found proved**

c. make a record of having undertaken the action referred to at paragraph 3b. **Found proved**

Patient B

4. On 12 December 2017 you consulted with Patient B and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient B's blood results not clearly indicating hypothyroidism; **Found proved**

b. prescribe appropriately in that you prescribed:

i. Levothyroxine 25mcg when this was not clinically indicated; **Found proved**

ii. a Cosmofer injection when Patient B did not have iron deficiency anaemia. **Found proved**

5. On 1 May 2018 you inappropriately prescribed for Patient B in that you increased Patient B's prescription of Levothyroxine to 100mcg daily when this was not clinically indicated. **Found proved**

Patient C

6. On 2 February 2018 you consulted with Patient C and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient C's blood results indicating a normal thyroid function. **Found proved**

7. On one or more of the dates set out in Schedule 3 you failed to:

    a. prescribe appropriately in that you:

        i. prescribed Levothyroxine for Patient C when it was not clinically indicated; **Found proved**

        ii. inappropriately increased the dose of Levothyroxine without undertaking further blood tests to see if Patient C's thyroid function had improved; **Found proved**

    b. obtain informed consent from Patient C in that you did not advise Patient C:

        i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

        ii. of the potential for Patient C to experience serious side-effects; **Found not proved**

    c. make a record of having undertaken the actions referred to at paragraph 7b. **Found proved**

8. On one or more of the dates set out in Schedule 4 you inappropriately prescribed diazepam for Patient C in that you prescribed it:

    a. outside of:

        i. BNF guidance; **Found not proved**

        ii. NICE guidance on the management of controlled drugs; **Found proved**

    b. without recording your rationale for doing so. **Found proved**

9. Between 2 February 2018 and 19 May 2020 you failed to communicate your prescribing of medication for Patient C to her NHS GP. **Found proved**

Patient D

10. On or around 13 April 2018 you consulted with Patient D and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient D's blood results indicating a normal thyroid function; **Found proved**

b. prescribe appropriately for Patient D in that you prescribed Levothyroxine 25mcg once daily when it was not clinically indicated; **Found proved**

c. obtain informed consent from Patient D in that you did not Patient D:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

ii. of the potential for Patient D to experience serious side-effects; **Found not proved**

d. make a record of having undertaken the actions referred to at paragraph 10c. **Found proved**

Patient E

11. On 14 April 2018 you consulted with Patient E and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism either:

a despite Patient E's blood results indicating a normal thyroid function or; **Found proved**

b without blood results **Found proved**

12. On one or more of the dates set out in Schedule 5 you failed to:

a. prescribe appropriately in that you:

i. prescribed Levothyroxine for Patient E when it was not clinically indicated; **Found proved**

ii. inappropriately increased the dose of Levothyroxine:

1. without undertaking further blood tests to see if her thyroid function had improved; **Found proved**

2. despite recent blood results indicating a normal thyroid function; **Found proved**

b. obtain informed consent from Patient E in that you did not advise Patient E:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

ii. of the potential for Patient E to experience serious side-effects; **Found not proved**

c. make a record of having undertaken the actions refer to at paragraph 12b. **Found proved**

13. You prescribed and/or administered a Cosmofer injection for Patient E when this was not clinically indicated on:

a. 13 June 2018; **Found proved**

b. 17 October 2018; **Found proved**

c. 21 March 2019. **Found proved**

14. Between 14 April 2018 and 11 June 2019 you failed to communicate your prescribing of opiates for Patient E to her NHS GP. **Found proved**

Patient F

15. On 14 February 2019 you consulted with Patient F and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient F's blood results indicating a normal thyroid function; **Found proved**

b. prescribe appropriately for Patient F in that you prescribed Levothyroxine 50mcg daily when it was not clinically indicated; **Found proved**

c. obtain informed consent from Patient F in that you did not advise Patient F:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

ii. of the potential for Patient F to experience serious side-effects; **Found not proved**

d. make a record of having undertaken the actions referred to at paragraph 15c. **Found proved**

16. On 12 June 2019 you consulted with Patient F and you failed to prescribe appropriately in that you increased the dose of Levothyroxine for Patient F:

a. when it was not clinically indicated; **Found proved**

b. without undertaking further blood tests to see if her thyroid function had improved. **Found proved**

Patient G

17. On 22 February 2019 you consulted with Patient G and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient G's blood results indicating a normal thyroid function. **Found not proved**

18. On one or more of the dates set out in Schedule 6 you failed to:

a. prescribe appropriately for Patient G in that you:

i. prescribed Levothyroxine when it was not clinically indicated; **Found proved**

ii. increased the dose of Levothyroxine for Patient G:

1. without undertaking further blood tests to see if her thyroid function had improved; **Found proved**

2. despite recent blood results indicating a normal thyroid function; **Found proved**

b. obtain informed consent from Patient G in that you did not advise Patient G:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

ii. of the potential for Patient G to experience serious side-effects; **Found not proved**

c. to make a record of having undertaken the actions referred to at paragraph 18b. **Found proved**

19. Your actions as described at paragraph 18 caused Patient G to become hyperthyroid as indicated by blood test results taken on:

a. 15 January 2019; **Found proved**

b. 6 December 2019. **Found proved**

20. You prescribed and/or administered a Cosmofer injection for Patient G when it was not clinically indicated on:

a. 14 July 2018; **Found proved**

b. 15 August 2018; **Found proved**

c. 1 March 2019. **Found proved**

Patient H

21. On 22 February 2019 you consulted with Patient H and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism without any blood results **Found proved**

b. prescribe appropriately in that you prescribed Levothyroxine 50mcg daily when it was not clinically indicated; **Found proved**

c. obtain informed consent from Patient H in that you did not advise Patient H:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

ii. of the potential to experience serious side-effects; **Found not proved**

d. make a record of having undertaken the actions referred to at paragraph 21c. **Found proved**

22. On 13 March 2019 you inappropriately prescribed for Patient H in that you increased the dose of Levothyroxine for Patient H:

a. when it was not clinically indicated; **Found proved**

b. without undertaking further blood tests to see if her thyroid function had improved. **Found not proved**

Patient I

23. On or around 12 September 2019 you consulted with Patient I and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient I's blood results indicating a normal thyroid function; **Found proved**

b. prescribe appropriately in that you prescribed Levothyroxine 50mcg once daily when it was not clinically indicated; **Found proved**

c. obtain informed consent from Patient I in that you did not advise Patient I:

i. that the decision to prescribe Levothyroxine was contrary to relevant guidance; **Found not proved**

ii. of the potential for Patient I to experience serious side-effects; **Found not proved**

d. make a record of having undertaken the actions referred to at paragraph 23c. **Found proved**

24. On one or more of the dates set out in Schedule 7 you failed to:

a. prescribe appropriately for Patient I in that you prescribed Methotrexate:

i. when it was not appropriate for you to do so without input from an appropriately qualified specialist; **Found proved**

ii. when Patient I had not been diagnosed with:

1. rheumatoid arthritis; **Found not proved**

2. psoriatic arthritis; **Found not proved**

iii. at a higher dose band than is advised in the BNF guidance: **Found not proved**

iv. without:

1. also prescribing folic acid to limit the side effects of Methotrexate; **Found proved**

2. arranging for Patient I to be monitored before initiation of Methotrexate; **Found not proved**

3. putting a plan in place for Patient I to be monitored on a weekly/fortnightly basis after initiation of Methotrexate; **Found proved**

4. advising Patient I's NHS GP of the prescription; **Found proved**

b. obtain informed consent from Patient I for the prescription of Methotrexate in that you did not advise Patient I:

i. of the possibility of serious adverse effects; **Found not proved**

ii. that overdose can be fatal; **Found not proved**

iii. that regular blood testing is essential; **Found not proved**

iv. that she should not conceive because Methotrexate is teratogenic; **Found not proved**

c. make a record of having undertaken the actions referred to at paragraph 24b. **Found proved**

Treatment of family members

Patient J

25. On one or more of the dates set out in Schedule 8 you inappropriately provided the treatment and/or care set out in Schedule 8 to Patient J with whom you had a close personal relationship, in that there was no necessary reason for you to treat Patient J on those occasions. **Found proved**

26. You prescribed for Patient J in relation to anxiety and/or depression but failed to undertake a suicide risk assessment on:

a. 8 December 2017; **Found not proved**

b. 3 January 2018. **Found not proved**

27. You failed to advise Patient J's NHS GP of the treatment you had provided as described at paragraphs 25-26. **Found proved**

Patient K

28. On one or more of the dates set out in Schedule 9 you inappropriately provided the treatment and/or care set out in Schedule 9 to Patient K with whom you had a close personal relationship, in that there was no necessary reason for you to treat Patient K on those occasions. **Found proved**

29. Between 3 November 2017 and 22 November 2018 you failed to advise Patient K's NHS GP of the treatment you had provided as described at paragraph 28. **Found proved**

30. On 3 November 2017 you consulted with Patient K and failed to:

a. take any history from Patient K's parent; **Found not proved**

b. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. Patient K's overall appearance; **Found not proved**

2. whether Patient K was alert; **Found not proved**

3. whether Patient K was distressed; **Found not proved**

ii. any basic physiological observations; **Found not proved**

iii. an examination of Patient K's chest; **Found not proved**

c. obtain informed consent from Patient K's parent in that you did not provide Patient K's parent with:

i. advice on the possible side effects of the medication you prescribed; **Found not proved**

ii. safety netting advice; **Found not proved**

d. prescribe appropriately in that you prescribed the following medication when it was not clinically indicated:

i. Phenergan; **Found not proved**

ii. Erythromycin; **Found not proved**

e. make a record of having undertaken the actions referred to at paragraph 30a-c. **Found proved**

31. On 16 October 2018 you consulted with Patient K and failed to:

a. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. Patient K's overall appearance; **Found not proved**

2. whether Patient K was alert; **Found not proved**

3. whether Patient K was distressed; **Found not proved**

ii. any basic physiological observations;
Found not proved

b. obtain informed consent from Patient K's parent in that you did not provide Patient K's parent with:

i. advice on the possible side effects of the medication you prescribed; **Found not proved**

ii. safety netting advice; **Found not proved**

c. prescribe appropriately in that you prescribed Co-amoxiclav when it was not clinically indicated; **Found not proved**

d. make a record of having undertaken the actions referred to at paragraph 31a-b. **Found proved**

32. On 21 November 2018 you consulted with Patient K and failed to:

a. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. Patient K's overall appearance; **Found not proved**

2. whether Patient K was alert; **Found not proved**

3. whether Patient K was distressed; **Found not proved**

ii. any basic physiological observations; **Found not proved**

b. obtain informed consent from Patient K's parent and that you did not provide Patient K's parent with:

i. advice on the possible side effects of the medication prescribed; **Found not proved**

ii. safety netting advice; **Found not proved**

c. make a record of having undertaken the actions referred to at paragraph 32a-b. **Found proved**

General clinical concerns

Patient L

33. On 8 March 2018 you consulted with Patient L and you failed to:

a. carry out an adequate examination in that you did not undertake:

i. a general examination to determine:

1. her overall appearance: **Found not proved**

2. whether she was alert: **Found not proved**

3. whether she was distressed; **Found not proved**

ii. basic physiological observations of Patient L's:

1. heart rate; **Found not proved**

2. respiratory rate; **Found not proved**

3. capillary refill time; **Found not proved**

4. oxygen saturation; **Found not proved**

b. prescribe appropriately in that you prescribed:

i. Co-amoxiclav when it was not clinically indicated;
Found not proved

ii. a Beclometasone inhaler when Beclometasone was an unlicensed treatment for someone of Patient L's age;
Found not proved

c. obtain informed consent from Patient L's parents:

i. for the prescription of Co-amoxiclav in that you did not provide Patient L's parents with:

1. advice on the potential side effects of the medication;
Found not proved

2. safety netting advice; **Found not proved**

ii. for the prescription of a Beclometasone inhaler in that you did not inform Patient L's parents that the prescription was:

1. outside of the licenced indication of the medication;
Found not proved

2. inconsistent with relevant guidance; **Found not proved**

d. make a record of having undertaken the actions referred to at paragraph:

i. 33a; **Found proved**
ii. 33c. **Found proved**

Patient M

34. On 29 May 2018 you consulted with Patient M and inappropriately prescribed one or more of the medications set out in Schedule 10 in that you:

a. prescribed the medication when it was not clinically indicated;
Found proved

b. failed to obtain any confirmatory evidence for Patient M's ongoing prescription; **Found proved**

c. failed to obtain any details of the psychiatric care Patient M may have been receiving; **Found proved**

d. prescribed the medication in excessive quantities. **Found not proved**

Patient N

35. On 14 May 2020 you consulted with Patient N and you failed to:

a. prescribe appropriately in that you prescribed Clopidogrel 75mg daily for anti-phospholipid syndrome:

i. when her condition had not been considered by an appropriately qualified specialist; **Found proved**

ii. in addition to an ongoing prescription of aspirin 300mg daily; **Found proved**

b. obtain informed consent from Patient N in that you did not advise Patient N that:

i. the decision to prescribe Clopidogrel was contrary to relevant guidance; **Found not proved**

ii. of the potential for Patient N to experience serious side-effects; **Found not proved**

c. make a record of having undertaken the actions refer to at paragraph 35b. **Found proved**

Interim Orders Tribunal ('IOT') breaches, IOT dishonesty and practising whilst suspended

36: On:

a. 12 July 2019 at an IOT hearing, your General Medical Council ('GMC') registration was made subject to the following conditions:

i. 'you should not provide medical services from [Tudor Medical Matters ('TMM')] until the clinic has had its registration confirmed by the Care Quality Commission ('CQC') ('Condition 1'); **Found proved**

ii. 'you must only prescribe opioids, benzodiazepines, hypnotics once you have communicated with the Patient's NHS GP and obtained the relevant medical records from them ('Condition 2'); **Found proved**

iii. 'you must not prescribe hormone treatments without face to face (in person) consultations with the Patients ('Condition 3'); Found proved

b. 18 November 2019, the IOT amended Condition 1 to 'you must not provide medical services from [TMM] until the clinic has had its registration confirmed by the CQC for those services' ('Condition 4'); Found proved

c. 6 January 2020, the IOT amended:

i. Condition 3 to 'you must not prescribe thyroxine unless you have communicated with the Patient's NHS GP and obtained the relevant medical records from them' ('Condition 5'); Found proved

ii. Condition 4 to 'you must not provide medical services from [TMM] clinic including diagnostic and screening procedures or the treatment of disease, disorder or injury unless the clinic has had its registration for these activities confirmed by the CQC' ('condition 6'). Found proved

37. Between 30 July 2019 and 26 May 2020 you breached one or more of the IOT conditions referred to in paragraph 36 as set out in Schedule 11. Found proved

38. When you carried out the actions referred to at paragraph 37 and Schedule 11 you knew your GMC registration was subject to the IOT conditions referred to at paragraph 36. Found proved

39. Your actions as described at paragraph 37 and Schedule 11 were dishonest by reason of paragraph 38. Found proved

40. You instructed your legal representative to falsely state, at an IOT review hearing on 6 January 2020, that the prescription you issued to Patient O on 26 November 2019, referred to in Schedule 11, was 'a single prescription and indeed it is the only prescription he has issued in the circumstances'. Found proved

41. When you instructed your legal representative to make the statement set out at paragraph 40 you knew you had also issued one or more other prescriptions between 12 July 2019 and 6 January 2020, as set out in Schedule 11. Found proved

42. Your actions described at paragraph 40 were dishonest by reason of paragraph 41. **Found proved**

43. You:

    a. had your registration with the GMC suspended by the IOT between 18 February 2020 and 5 May 2020; **Found proved**

    b. provided clinical care to patients between 2 March 2020 and 5 May 2020 as set out in Schedule 12. **Found proved**

44. When you provided the clinical care described in paragraph 43b and Schedule 12 you knew:

    a. your GMC registration was suspended as described in paragraph 43a; **Found proved**

    b. that the suspension of your GMC registration meant that you should not provide clinical care. **Found proved**

45. Your actions described at paragraph 43b where dishonest by reason of paragraph 44. **Found proved**

Care Quality Commission ('CQC') Conviction for TMM

46. You were responsible for ensuring that TMM was registered with the CQC to carry out regulated activities as defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('the Regulations'). **Found not proved**

47. You inappropriately provided diagnostic and screening procedures ('DSP'), a regulated activity, for patients at TMM between 19 July 2017 and 10 September 2019, when TMM did not have the necessary registration with the CQC to carry out DSP, in breach of the Regulations. **Found proved**

48. You inappropriately provided treatment of disease and injury ('TDDI'), a regulated activity, to patients at TMM between 19 July 2017 and 14 February 2020 when TMM did not have the necessary registration with the CQC to carry out TDDI, in breach of the Regulations. **Found proved**

Determination on Impairment - 14/08/2023

1. This determination will be handed down in private under the provisions of Rule 41 of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). A redacted version will be published at the close of the hearing.

2. 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 before, Dr Tudor's fitness to practise is impaired by reason of misconduct.

The Evidence

3. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further evidence as follows.

4. The Tribunal also received a bundle from Dr Tudor which contained various documents, which included but was not limited to:

- Two undated written statements from Dr Tudor (the first two documents in his Stage 2 bundle);
- Continuing Professional Development (CPD) certificates, various dates; and
- A number of testimonials from patients at TMM.

5. Dr Tudor also gave oral evidence at the hearing.

6. The Tribunal was concerned by Dr Tudor's underlying attitude whilst giving oral evidence at the hearing. It considered that the doctors oral explanations given at the hearing were at times variously vague, inconsistent and evasive. There were occasions when the Tribunal noted an element of what borders on contempt for the proceedings.

7. By way of example, it became clear at the start of the stage 2 hearing that Dr Tudor had not read the lengthy fact-finding determination, dated 2 February 2023. He claimed to have 'skim read' it. It was not clear what this meant in practice. He was urged by the chair to read the determination, or at least some paragraphs to which specific reference was made. Even at the end of day three of the hearing, it was apparent that he had not done so. Given the gravity of the findings, this would have been surprising in any event, but given Dr Tudor was attempting to represent himself, it beggared belief that he would adopt that attitude to the proceedings.

8. The Tribunal found that Dr Tudor's failure to read the Tribunal's facts determination was illustrative of a of deep-rooted attitude towards the regulatory matters, the proceedings in general, and to the allegations that had been found proved. It was, above all else, unprofessional, and was, the Tribunal's view, a continuation of an attitude shown towards the CQC and the IOT.

9. The Tribunal noted that, throughout the Stage 2 hearing, Dr Tudor continued to deny many of the allegations which it had found proven. This was, to some extent, understandable. He had not attended the previous hearing. He clearly felt he had not contributed adequately to the fact-finding process. Of course, he had chosen not to attend. However, it was the Tribunal's view that it would have assisted Dr Tudor in coming to terms with this issue to have read the determination. By way of example, Dr Tudor made repeated reference to our findings relating to allegations 43-45. It was an allegation that he had continued to issue prescriptions whilst suspended. He was adamant that he did not accept this allegation in particular. He stated that TMM had employed locums when he was suspended on 18 February 2020, and referred to extracts from the TMM diary in support. The Tribunal's findings on the issue can be found at paragraphs 94-117. It gave very detailed reasons, which included consideration of TMM diary extracts provided by Dr Tudor during the course of the fact finding hearing.

10. Dr Tudor produced a 'Stage 2' document which evidenced that Dr Tudor had undertaken online CPD. The Tribunal considered that most of the CPD courses did not seem to be targeted. It noted that the CPD courses were all undertaken in June 2023 – and that Dr Tudor appeared to have undertaken 17 of the CPD courses in one day – each individually required an hour for completion.

11. The Tribunal considered Dr Tudor's general approach seemed to be cavalier and did not focus on, or reflect, the issues that had been raised in this case.

12. Further, the Tribunal considered that, since Dr Tudor told the Tribunal that he had not worked as a GP since 1995, other that at Pall Mall and at TMM, it appeared that the doctor had not updated his knowledge apart from a flurry of online CPD undertaken immediately prior to the current hearing.

13. The Tribunal was concerned that Dr Tudor's lack of evidence of knowledge and skills demonstrated an insufficient understanding of the need for him to acquire and update his skills necessary for future practice.

14. Dr Tudor provided the Tribunal with a number of testimonials from patients. They were all very positive about their experience of having Dr Tudor as their private GP. However, the Tribunal found it was able to place only very limited weight on these as it was not clear how they were obtained or what the authors of the testimonials knew about the nature of these proceedings. By way of example, one of the testimonials came from Patient A who made no mention of her view of her role in these matters.

Submissions

Submissions on behalf of the GMC

15. Ms Rollings submitted that Dr Tudor's fitness to practise was currently impaired by reason of his misconduct.

16. Ms Rollings referred to *Good Medical Practice* (2013) ('GMP') and referenced relevant case law. She also emphasised that the Tribunal should have regard to all three limbs of the overarching objective.

17. Ms Rollings submitted that it was of particular concern that during the hearing Dr Tudor had demonstrated a serious and persistent lack of insight into his own *'now proven'* misconduct. She stated that, by way of example, Dr Tudor had failed to recognise and accept, upon reflection, the harm he caused to his patients when he prescribed them drugs which were not clinically indicated.

18. Ms Rollings stated that Dr Tudor's lack of insight into his own conduct extended also to his attempts to justify the use of medication by arguing that it was only a 'low dose'. She stated that the Tribunal had already determined that higher doses of levothyroxine were used in circumstances where blood tests did not inform this management, contrary to clinical guidelines.

19. Ms Rollings submitted that Dr Tudor's conduct in relation to prescribing medication contrary to clinical guidelines flew in the face of the Hippocratic oath, namely *'first of all do no harm'*.

20. Ms Rollings submitted that the Tribunal's three findings of dishonesty were particularly serious and argued that, on a cumulative basis, these findings alone amount to impairment. She stated that Dr Tudor had been dishonest to the CQC, whilst under caution in a PACE interview, and on other occasions; and he had also been dishonest to the Tribunal and consequently that a presumption of impairment therefore applied here.

21. In relation to matters surrounding Dr Tudor's CQC registration, Ms Rollings submitted that the doctor had been in *'flagrant'* breach of the regulations (quoting paragraph 43 of the facts determination). She further argued that Dr Tudor had demonstrated an arrogance towards serious matters in relation to patient safety and, whilst he had shown some insight by saying that he would do things differently in relation to the CQC registration, he did not appear to have understood the seriousness of what had been found proven.

22. Ms Rollings submitted that Dr Tudor's lack of insight and arrogance towards compliance with rules and regulations was further demonstrated when the doctor continued working in breach of his interim order of conditions.

23. Further, Ms Rollings argued that Dr Tudor's instruction to his barrister Mr Dawson, to present incorrect information to an IOT in relation to a *"one-off prescription"* was particularly serious. She stated that Dr Tudor had shown no insight whatsoever in relation to the seriousness of the conduct and the inappropriateness of him provided such instruction to his representative.

24. Ms Rollings stated that Dr Tudor's sustained misconduct had been compounded by what appeared to be a persistent lack of insight on the part of the doctor who, whilst quoting GMP within his disclosure did not appear to have truly understood its contents. She submitted that this is a matter of serious concern, in terms of protecting the public interest.

25. Ms Rollings conceded, in response to a question from the Tribunal, that the GMC did not consider Dr Tudor's actions in treating family members to constitute serious misconduct.

26. Ms Rollings concluded by submitting that there was an underlying and continuing theme of Dr Tudor failing to abide by rules and regulations in relation to his practice, at TMM, and whilst practising as a doctor. She stated that during the course of the hearing, it had come to light that between 1995 and 2015, Dr Tudor did not practise as a GP and that he made no proactive attempts to retrain following this lengthy period out of practice. Further, she stated that when he did return, twenty-one years after he had left practice, what

followed was a series of gravely concerning events surrounding patient safety and a wilful disregard to follow guidelines and rules. She emphasised that Dr Tudor's answers during cross-examination, for *example "I'd be better controlled in an NHS Practice"*, *"I think outside the box"* (in relation to not following guidelines) and *"I didn't consider myself a criminal for my actions* [sic] *I know it's a fine point"* (in relation to failing to register with the GMC) had been particularly troubling.

Dr Tudor's Submissions

27. Dr Tudor admitted that he treated patients at TMM with levothyroxine against the guidelines and stated that he should not have treated patients as their TSH levels were not outside the reference range in the UK. However, he stated that nonetheless, *'all the symptoms referable to a diagnosis of hypothyroidism experienced by the patients improved considerably with treatment'* and that he had obtained informed consent. He stated that he had reflected and assured the MPTS and the GMC that he would not prescribe levothyroxine against guidelines in the future.

28. With regard to methotrexate Dr Tudor stated that he prescribed methotrexate to patients who were suffering symptoms and signs of inflammatory arthritis.

29. Dr Tudor stated that he was advised to prescribe methotrexate to one patient by a consultant rheumatologist as a prednisolone-sparing measure. He stated that the consultant also advised him to prescribe folic acid to be taken concurrently with methotrexate, but that he *'inadvertently overlooked'* this. He noted that methotrexate has significant side effects which can be offset by folic acid and that he should not have initiated treatment personally with methotrexate, and that he deeply regretted this.

30. In relation to controlled drugs, Dr Tudor stated that he had considered the information contained in 'NICE Guidance – Safe use and Management of Controlled Drugs' which he would refer to if he must prescribe controlled drugs in future. He stated that he *'made a mistake'* when prescribing controlled drugs to a PMM patient and that he had no intention of repeating that mistake.

31. With regard to treating family members he stated that he had treated XXX for an exacerbation of bronchial asthma/RTI (respiratory tract infection) with beclometasone and salbutamol sprays albeit in small doses, as well as antibiotics. However, he stated that he had obtained informed consent from XXX. He acknowledged that he should have referred his XXX

and XXX back to their own GP for treatment. Further, he stated that he was deeply sorry for not doing this.

32. Dr Tudor accepted that it was his responsibility to ensure registration with the CQC to carry out regulated activities. He stated that he should have arranged registration with the CQC before TMM opened in April 2017 but *'due to some confusion on my part'*, he did not apply for registration until sometime in 2018. He stated that the process was unduly protracted and that he had engaged a firm called CQC Assist to help and that he truly regretted not having the registration in place initially.

33. Dr Tudor stated that there would be no repetition in relation to CQC registration because going forward he would like to work as an NHS GP and that he never wanted to work as a private GP again.

34. Dr Tudor maintained that he was not dishonest. However, he noted that he had been found to be dishonest in relation to having advised his representative at his IOT hearing that a prescription issued contrary to conditions was *'a one-off'* . He acknowledged that he had issued other prescriptions contrary to his interim order of conditions and could not explain why he had instructed his representative that the prescription was a one-off as he was fully aware of the restrictions imposed upon him at the time. He stated that, at this stage, all he could do is apologise unreservedly for his behaviour which was totally out of character.

35. Dr Tudor disputed that he had seen patients between March and May 2020 whilst he was suspended. He stated that the Tribunal had based their finding on the patient records which for some reason had shown him as the consulting doctor which was not the case. He stated that he had since found out that the name appearing in the relevant column of the clinic records was dependent on the credentials of the person logged in to the system. He stated that between March and May 2020 locums had logged in using his credentials hence the confusion. He said that he *'did not wish to make matters worse'* but that he disagreed with the Tribunal's finding in this regard.

36. Dr Tudor submitted that he had demonstrated full insight into the matters raised above and assured the Tribunal that there would be no possibility of repetition because he would like to work as a GP in the NHS if it allowed him to stay on the register.

37. Dr Tudor submitted that he had completed a lot of CPD so far to show the GMC/MPTS that he was attempting to keep up to date with *'matters medical'* – and he intended to do more CPD in the future.

38. Dr Tudor concluded by stating that he had considered GMP and confirmed that in future he would *'faithfully adhere to the principles contained therein'* and emphasised that he had not breached any of the conditions/ restrictions imposed on him for at least the last three years and three months which he hoped the Tribunal would consider when reaching a decision as to his fitness to practise.

The Relevant Legal Principles

39. 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.

40. 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 that the misconduct was serious; and then whether the finding of that misconduct which was serious, could lead to a finding of impairment.

41. The Tribunal must determine whether Dr Tudor's fitness to practise is impaired today, taking into account Dr Tudor's conduct at the time of the events and any relevant factors since then, such as whether the matters are remediable, have been remedied, and any likelihood of repetition. The Tribunal was also obliged to consider whether a finding of impairment was required on public interest grounds.

42. The Tribunal also had regard to the case of *Meadow v General Medical Council* [2006] EWCA Civ 1390 in which Auld LJ quoted Collins J approvingly in the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) where he said that serious misconduct would be *'conduct which would be regarded as deplorable by fellow practitioners'.*

43. With regard to impairment, the Tribunal had regard to the case of *CHRE v NMC and Grant* [2011] EWHC 927 where Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed. Dame Janet Smith suggested that questions of impairment could be considered in the light of the following considerations:

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

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 brought 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.'

The Tribunal's Determination on Impairment

Misconduct

44. The Tribunal took GMP into account when considering whether Dr Tudor's actions amounted to misconduct, in particular:

'7 You must be competent in all aspects of your work, including management, research and teaching'

'11 You must be familiar with guidelines and developments that affect your work.'

'12 You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.'

'13 You must take steps to monitor and improve the quality of your work.'

'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

b promptly provide or arrange suitable advice, investigations or treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs'

'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'

g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship'

'17 You must be satisfied that you have consent or other valid authority before you carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research'

'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.'

'44 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

a share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers'

'56 You must give priority to patients on the basis of their clinical need if these decisions are within your power. If inadequate resources, policies or systeMs Rrevent you from doing this, and patient safety, dignity or comfort may be seriously compromised…'

'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.'

'72 You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information.

b You must not deliberately leave out relevant information.'

Hypothyroidism Patients

45. The Tribunal again had regard to The Royal College of Physicians (RCP) guidance: The diagnosis and management of primary hypothyroidism, dated 14 June 2011, which states:

"The diagnosis and management of primary hypothyroidism

Hypothyroidism, under-activity of the thyroid gland, is common. It can make people unwell and should be treated with levothyroxine tablets, a synthetic form of the thyroid hormone thyroxine (also abbreviated to T4). Symptoms of hypothyroidism, for example tiredness, are not specific to under-activity of the thyroid gland, and occur in many other situations. It is

important to diagnose hypothyroidism with a blood test, because it can be ***dangerous*** [the Tribunal's emphasis] *to take levothyroxine or other thyroid hormones* ***if they are not needed****. We are therefore very concerned that some patients with and without thyroid disease are being inappropriately diagnosed and managed, using levothyroxine and other thyroid hormones, in ways which compromise patient safety. This is potentially an enormous problem, given that, in any one year, one in four of the population have their thyroid function checked.*

The vast majority of patients with suspected thyroid disease are supported very well in primary care by their GPs, and their condition, hypothyroidism or otherwise, is appropriately diagnosed and well managed. ***However, some patients are inappropriately diagnosed as being hypothyroid (often outside the NHS) and are started on levothyroxine or other thyroid hormones, which will not only cause them possible harm, but leaves the true cause of their symptoms undiagnosed and therefore untreated.*** *This statement refers only to primary hypothyroidism. Secondary hypothyroidism is a different condition and should be managed by accredited endocrinologists in the same way as all other diseases of the pituitary gland.*

Diagnosis of primary hypothyroidism

(a) The symptoms of hypothyroidism are very common, both in many other conditions and even in states of normal health. It is therefore essential that thyroid function is tested biochemically alongside a careful clinical assessment of the individual patient. Clinical symptoms and/or signs alone are insufficient to make a diagnosis of hypothyroidism.

(b) The only validated method of testing thyroid function is on blood, which must include measurement of the levels of thyroid stimulating hormone (TSH) and free thyroxine (FT4) in serum.
…..

*(d) The results of blood tests for thyroid function can be influenced by other factors, for example in some illnesses which do not permanently damage the thyroid gland. In this case the tests will return to normal after the illness and thyroid hormone therapy is not needed (****and can be harmful****).*
….

Treatment of primary hypothyroidism

(a) The aim of the treatment of hypothyroidism is to render the patient back to the normal or 'euthyroid' state.

(b) When a sufficient dose of thyroid treatment is given to lower the TSH to within the normal range (reference range) for the test method used, patients usually recover from their symptoms of hypothyroidism.
….

Patients with normal thyroid function tests

(a) We recommend that those patients whose thyroid blood tests are within the reference ranges but who have continuing symptoms, whether on levothyroxine or not, should be further investigated for the non-thyroid cause of the symptoms.
….."

46. The Tribunal had further regard to the NICE guidance for rheumatoid arthritis which states that:

"Rheumatoid arthritis: Summary

- *Rheumatoid arthritis (RA) is a chronic systemic inflammatory disease.*

o RA typically presents as inflammatory arthritis affecting the small joints of the hands and the feet (usually both sides equally and symmetrically) although any synovial joint can be involved.
o As RA progresses, any system of the body may be affected, leading to an increased risk of premature death.
o RA is associated with a number of complications and comorbidities, such as an increased risk of cardiovascular disease, osteoporosis, anaemia, and infection.
…

- *Clinical features of synovitis include pain, swelling, heat and stiffness in affected joints.*

….

- ***Management of RA should be managed under specialist care*** [Tribunal's emphasis]*, where a treat to target strategy is used - the aim is to achieve a target of remission or low disease activity if remission cannot be achieved.*

- *Specialists will usually offer a conventional disease modifying anti-rheumatic drug (cDMARD) as monotherapy - for example, oral methotrexate, leflunomide, or sulfasalazine. The dose is increased depending on tolerance*.

47. The Tribunal also had regard to its acceptance of the expert witness evidence of Dr AC at the fact-finding stage of the hearing, in particular the following:

'125. Dr AC told the Tribunal that hypothyroidism can only be safely diagnosed by reference to results of blood tests and that this was clearly set out in the guidance from the RCP.'

'126. It was Dr AC's view that it was inappropriate to base a diagnosis of hypothyroidism on the patients' clinical symptoms and/or family history. The Tribunal accepted this evidence.'

'142. Dr AC also told the Tribunal that because of the significant side effects when methotrexate was prescribed, there should be counselling of the patient, during which they should be made aware of these side effects, the dose they should take and how often they should take it. There should be a monitoring plan put in place with blood tests taken every 1-2 weeks initially, until stable.'

'143. Dr AC made the observation that methotrexate was banned in some countries and restricted in certain states in America because it can cause deformity to a foetus and therefore be used to induce abortion. He stressed that caution needed to be taken when prescribing it to women of childbearing age.'

'144. Dr AC referred the Tribunal to a leaflet 'NHS: National Patient Safety Agency – methotrexate treatment', which should be given to patients as part of their counselling…'

Patient A

48. The Tribunal reminded itself of its findings in relation to Patient A, namely that Dr Tudor's had failed to make an appropriate diagnosis in that he diagnosed hypothyroidism despite Patient A's blood results indicating a normal thyroid function; had failed to prescribe appropriately in that he prescribed levothyroxine for Patient A when it was not clinically indicated and failed to make a record of prescribing levothyroxine.

49. It also noted that Dr Tudor had failed to prescribe appropriately in that he prescribed methotrexate when it was not appropriate without input from a qualified specialist; and when Patient A had not been diagnosed with rheumatoid arthritis or psoriatic arthritis.

50. Further, the Tribunal noted that Dr Tudor had failed to prescribe appropriately in that he prescribed methotrexate for Patient A when he did not also prescribe folic acid to limit the side effects of methotrexate; arrange for Patient A to be monitored before initiation of methotrexate; put a plan in place for Patient A to be monitored on a weekly/fortnightly basis after initiation of methotrexate; advise Patient A's NHS GP of the prescription; obtain informed consent from Patient A in that he did not adequately counsel Patient A on the use of methotrexate, and did not record having done so.

51. The Tribunal considered that Dr Tudor's failure to make a record in relation to prescribing levothyroxine to constitute misconduct, but not serious misconduct. A failure to keep proper records was clearly contrary to GMP. Record keeping is important. The question

for the Tribunal was whether, in the context of diagnosis and treating hypothyroidism, it was serious misconduct. The risks associated with the use of levothyroxine were, in the Tribunal's view, somewhat less than those presented by methotrexate and/or controlled drugs. Further, the risk to patients was not readily attributable to the quality of the records. On balance, and not without some hesitation, the Tribunal took the view that it was not serious misconduct in this context.

52. However, the Tribunal considered that Dr Tudor's actions in relation to the other findings in relation to Patient A to constituted serious misconduct due to the serious failings involved. Dr Tudor had diagnosed a serious condition without blood tests, in obvious breach of the applicable guidelines, and had inappropriately treated in a way which gave rise to risk to the patient. The guidelines stress that it is important to diagnose hypothyroidism with a blood test, because it can be dangerous to take levothyroxine if it is not indicated. Those patients who are inappropriately diagnosed as being hypothyroid and are started on levothyroxine, would be at risk of possible harm, and leave the true cause of their symptoms undiagnosed and therefore untreated.

53. The Tribunal found that Dr Tudor's failings in relation to the prescribing of methotrexate to Patient A amounted to serious misconduct because it gave rise to potentially serious consequences for the patient.

54. As set out above, methotrexate is potentially a highly toxic drug. Accordingly, it should only be initiated under the care of a specialist, and with very carefully management. These measures were almost wholly disregarded by Dr Tudor, in flagrant breach of appropriate guidelines. Due to the increased toxicity of the drug, and the need for planned and recorded management, the Tribunal found that a failure to keep records in relation to Patient A did amount to serious misconduct. It also noted its findings at the fact-finding stage, in particular:

'191. In light of the unusual steps taken by Dr Tudor in prescribing methotrexate to Patient A on the strength of a telephone call with her husband, the Tribunal would have expected to have seen a note in the medical record on 6 June 2019 detailing the specific counselling and obtaining of consent. However, there was nothing to that effect. '

55. In the circumstances, the Tribunal concluded that Dr Tudor's failures in relation to his treatment of Patient A, other than his failure to record prescribing levothyroxine, constituted serious misconduct.

Patient B

56. The Tribunal considered Dr Tudor's failure to make an appropriate diagnosis in that he diagnosed hypothyroidism despite the fact that Patient B's blood results did not support such a diagnosis. It also took account of his failure to prescribe appropriately in that he prescribed levothyroxine when this was not clinically indicated; and a Cosmofer injection when Patient B did not have iron deficiency anaemia.

57. The Tribunal noted the expert evidence it received regarding Cosmofer injections, and in particular, the evidence that such injections are painful. Further, that they give rise to the potential for serious side effects such as anaphylaxis. It further noted that Cosmofer injections are not a first-line treatment for anaemia. There were other treatments which were safer. For those reasons, the Tribunal considered that the use of this medication was serious misconduct.

58. The Tribunal also considered Dr Tudor's diagnosis of hypothyroidism, and the inappropriate prescribing of levothyroxine, including increasing the dose, when not clinically indicated, amounted to serious misconduct. It took this view for similar reasons as detailed for Patient A.

59. The Tribunal considered that all of Dr Tudor's failures in relation to his treatment of Patient B clearly constituted serious misconduct.

Patient C

60. The Tribunal considered Dr Tudor's failure to make an appropriate diagnosis of hypothyroidism as Patient C's blood results indicated a normal thyroid function.

61. It considered that this was clearly a serious failing and, as such, constituted serious misconduct. It took this view for similar reasons as detailed for Patient A.

62. The Tribunal considered that Dr Tudor's failure to make a record prescribing levothyroxine constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

63. The Tribunal further considered Dr Tudor's inappropriate prescribing of diazepam (a controlled drug) to Patient C outside of the matters contained in NICE guidance on the management of controlled drugs.

64. Further, that Dr Tudor had done so without recording his rationale for doing, and without communicating his prescribing of diazepam to Patient C's NHS GP. It considered that this was clearly far below the acceptable standards and clearly constituted serious misconduct.

65. Controlled drugs are drugs that are subject to high levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful. They present a particular and high risk to patients if they are not prescribed appropriately in accordance with any applicable guidance. It was the Tribunal's view that Dr Tudor had had scant regard to these matters when prescribing a controlled drug to Patient C. Primarily for these reasons, it was the Tribunal's judgment that the failures in relation to Patient C amounted to serious misconduct.

Patient D

66. The Tribunal considered that Dr Tudor's failure to make an appropriate diagnosis in that he diagnosed hypothyroidism despite Patient D's blood results indicating a normal thyroid function, and his failure to prescribe appropriately, was clearly unacceptable and constituted serious misconduct. It took this view for similar reasons as detailed for Patient A.

67. In relation to Dr Tudor's failure to make an adequate record of his prescribing of levothyroxine constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

Patient E

68. The Tribunal had found that Dr Tudor failed to make an appropriate diagnosis of hypothyroidism, and prescribed levothyroxine, which was not clinically indicated. Dr Tudor had also increased the dose of levothyroxine, when not appropriate. The Tribunal considered that this was seriously below a standard expected of a doctor and constituted serious misconduct. It took this view for similar reasons as detailed for Patient A.

69. In relation to Dr Tudor's failure to make a record of having prescribed levothyroxine, the Tribunal considered that this constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

70. The Tribunal considered that Dr Tudor's prescribing and/or administering of a Cosmofer injection for Patient E when this was not clinically indicated was seriously below a standard expected of a doctor and constituted serious misconduct. It took this view for similar reasons as detailed for Patient B.

71. Further, the Tribunal considered that Dr Tudor's failure to communicate his prescribing of an opiate (Oromorph) for Patient E to her NHS GP was a serious failing and potentially a risk to Patient E's health. The Tribunal noted its earlier finding, in particular:

'275. Whilst the opiates Dr Tudor prescribed to Patient E were not a controlled drug, the Tribunal noted that there was a clear danger if patients received opiates from both a private GP and an NHS GP, where there has been no communication from the private GP.'

Accordingly, this constituted serious misconduct.

Patient F

72. Again, Dr Tudor had failed to make an appropriate diagnosis of hypothyroidism and had prescribed levothyroxine and on another occasion had increased the dose, outside of the applicable guidelines. The Tribunal considered that these matters constituted serious misconduct. It took this view for similar reasons as detailed for Patient A.

73. In relation to Dr Tudor's failure to make a record of having prescribed levothyroxine, the Tribunal considered that this constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

Patient G

74. The Tribunal considered its findings in relation to Dr Tudor's practice with regard to the diagnosis and treatment of hypothyroidism was clearly below acceptable standard expected of a doctor and constituted serious misconduct. It took this view for similar reasons as detailed for Patient A.

75. In relation to Dr Tudor's failure to make a record of having prescribed levothyroxine, the Tribunal considered that this constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

76. It was an aggravating feature for this patient that Dr Tudor had over-treated Patient G to such an extent as to cause symptoms of hyperthyroidism. There was clear evidence that the patient had actually been caused harm by Dr Tudor's actions. The Tribunal was satisfied that this in particular would have been regarded by fellow professionals as 'deplorable' and was therefore serious misconduct.

77. The Tribunal also concluded that Dr Tudor's actions in prescribing/administering Cosmofer injection for Patient G when it was not clinically indicated on three occasions had the potential for serious side-effects for the patient and amounted to serious misconduct. It took this view for similar reasons as detailed for Patient B.

Patient H

78. The Tribunal considered that Dr Tudor's failure to make an appropriate diagnosis in that he diagnosed hypothyroidism without any blood tests, and his failure to prescribe appropriately, was clearly unacceptable and constituted serious misconduct. It took this view for similar reasons as detailed for Patient A.

79. In relation to Dr Tudor's failure to make an adequate record of his prescribing of levothyroxine constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

Patient I

80. Patient I was also been inappropriately diagnosed with, and treated for, hypothyroidism. The Tribunal concluded that this was serious misconduct per its findings under Patient A.

81. In relation to Dr Tudor's failure to make an adequate record of his prescribing of levothyroxine constituted misconduct but not serious misconduct. It took this view for similar reasons as detailed for Patient A.

82. The Tribunal noted that Dr Tudor prescribed methotrexate for Patient I when it was not appropriate for him to do so without input from an appropriately qualified specialist.

83. Further, it noted that Dr Tudor prescribed methotrexate without also prescribing folic acid to limit the side effects; without arranging for Patient I to be monitored before initiation of methotrexate; without putting a plan in place for Patient I to be monitored on a weekly/fortnightly basis after initiation of methotrexate; and without advising Patient I's NHS GP of the prescription.

84. The Tribunal also took into account Dr Tudor's failure to record his prescription of methotrexate and considered that such a failing was serious misconduct in light of the potentially serious side-effects from prescribing such a drug.

85. The Tribunal concluded that Dr Tudor's failings in relation to prescribing methotrexate to Patient I put the patient's health at risk and were clearly inappropriate and amounted to serious misconduct. It took this view for similar reasons as detailed for Patient A.

Treatment of family members

Patients J and K

86. The Tribunal considered its findings in relation to Dr Tudor's treatment of his family members.

87. The Tribunal noted the position of Dr Tudor and the GMC.

88. The Tribunal considered that Dr Tudor's actions in inappropriately treating family members, and failing to make records of having done so, was not in line with GMP paragraph 16(g).

89. However, the Tribunal considered that there was no suggestion that Dr Tudor did not have the best intentions when treating XXX and XXX. It considered that his actions in treating his family members were well intentioned albeit misguided.

90. It further noted that not all incidents of a GP treating their family members would amount to serious misconduct. In this case, The Tribunal were told by Ms Rollings that the

GMC did not suggest that this amounted to serious misconduct in relation to either Patient J or K.

91. In the circumstances that Tribunal concluded that these actions constituted misconduct but did not constitute serious misconduct.

General clinical concerns: Patient L

92. The Tribunal considered that Dr Tudor's failure to record adequate details of the consultation with Patient L on 8 March 2018. It concluded that this failure constituted misconduct but not serious misconduct. A failure to keep proper records was clearly contrary to GMP. Record keeping is important. The question for the Tribunal was whether, in the context of this consultation, it was serious misconduct. The risks associated with this patient were limited in the Tribunal's view. Further, the risk to the patient was not readily attributable to the quality of the records. On balance, the Tribunal took the view that it was not serious misconduct in this context.

Patient M

93. It was a key feature of this case that Patient M was dependent on controlled drugs. It was apparent to Dr Tudor at the time of the consultations, that Patient M was an addict. The Tribunal considered that by inappropriately prescribing one or more of the controlled drugs set out in Schedule 10 when it was not clinically indicated; and by failing to obtain any confirmatory evidence for Patient M's ongoing prescription; and by not obtaining any details of the psychiatric care Patient M may have been receiving; Dr Tudor was clearly acting inappropriately in a way which constituted serious misconduct such that fellow professionals would regard it as deplorable.

Patient N

94. Dr Tudor's prescribed clopidogrel 75mg daily for anti-phospholipid syndrome when it was inappropriate to do so. This type of intervention required a qualified specialist. In addition, Dr Tudor was aware that the patient was taking aspirin, which along with clopidogrel, amounted to dual platelet therapy. This presented a risk of serious side effects for the patient.

95. The Tribunal considered that by prescribing clopidogrel for Patient N that Dr Tudor was acting outside his competency as a GP.

96. Consequently, the Tribunal concluded that Dr Tudor's conduct in relation to Patient N constituted serious misconduct, save for paragraph 35(c) of the Allegation which the Tribunal found was misconduct rather than serious misconduct.

Interim Orders Tribunal ('IOT') breaches, IOT dishonesty and practising whilst suspended

97. The Tribunal considered that Dr Tudor's actions in dishonestly breaching one or more of his IOT conditions clearly constituted serious misconduct and undermined the regulatory system.

98. Further, it considered that such conduct would be considered to be deplorable by fellow professionals.

99. The Tribunal also considered that Dr Tudor's actions in dishonestly instructing his legal representative to falsely state, at an IOT review hearing on 6 January 2020, that a prescription issued to Patient O on 26 November 2019, was 'a single prescription' was a deliberate lie.

100. The Tribunal noted Dr Tudor's testimony that the clinic had been open for business as usual both before and after the IOT of 6 January 2020. He had been the only doctor working at the practice at the time. He could give no explanation as to who else was signing the numerous other prescriptions issued between 12 July 2019 and 6 January 2020, as set out in Schedule 11. Dr Tudor told the Tribunal that the information he had given to his counsel had been *'true to the best of my knowledge and belief'*. When asked though, he admitted that he had made no checks to ascertain whether there had been more prescriptions. Indeed, we found that Dr Tudor had held consultations, and issued prescriptions, on 3 and 4 January 2020. It was plain that Dr Tudor had lied to the IOT, and that he continued to lie to the Tribunal.

101. In the circumstances, the Tribunal found that Dr Tudor's actions in breaching his IOT conditions and dishonestly instructing his legal representative clearly constituted serious misconduct and would be considered deplorable to fellow professionals by any measure. That Dr Tudor seemed unable to accept this was a further source of puzzlement to the Tribunal.

102. The Tribunal also considered that Dr Tudor's actions in dishonestly providing clinical care when he knew that he was suspended from the medical register clearly constituted serious misconduct.

Care Quality Commission ('CQC') Conviction for TMM

103. The Tribunal considered that Dr Tudor's actions in inappropriately providing regulated activities for patients at TMM between 19 July 2017 and 14 February 2020 clearly amounted to serious professional misconduct. In effect, Dr Tudor had practised at TMM, as the sole doctor, from April 2017 to 14 February 2020, without being properly regulated to diagnose and treat patients. This is the core business of such a clinic. He must have 'opened the doors' knowing this was the case, and steadfastly resisted all suggestions that he should rectify the position the told to do so by CQC and GMC. Not even the imminent threat of criminal sanction persuaded Dr Tudor to cease trading pending registration. In the Tribunal's view, this was conduct close to the top end of seriousness for a medical professional.

Impairment

104. The test that the Tribunal has to apply when looking at impairment is to look at both individual allegations of serious misconduct found proved but also the cumulative effect of any serious misconduct.

105. The Tribunal considered that Dr Tudor's serious misconduct had ignored important prescribing guidelines and shown a complete disregard for the CQC and GMC regulatory framework. He had thereby undermined public trust in the profession, good professional medical standards, and put patients at risk.

106. The Tribunal was concerned that Dr Tudor had repeatedly stated that he had found the attitude of the CQC to be *'appalling'* and that the doctor did not accept the findings of the Tribunal and seemed to be impervious to criticism. Dr Tudor had a tendency to deflect any negative observation about him, preferring instead to dwell on the failings of others, including the legal profession and CQC consultants.

107. The Tribunal also noted that Dr Tudor had not read the facts determination. It considered that to have read the facts determination was an essential first step to insight and

reflection, particularly as he was not present at the opening of the case and the fact-finding stage of the hearing.

108. It was the Tribunal's firm view that Dr Tudor did not have a full understanding of the seriousness of the Allegations and that he had struggled to accept that he had done anything wrong, even when the allegations were so serious, and the evidence overwhelming.

109. The Tribunal also noted that on at least three occasions – including at the PACE interview with two staff from the CQC, during which he was told that continuing to provide medical care without registration was a criminal offence, he continued to treat patients. When Dr Tudor was asked to comment about this in his oral evidence he replied that, in his judgement, to carry on seeing patients did not amount to criminality. The Tribunal was surprised and alarmed that Dr Tudor could maintain that view. It considered that Dr Tudor was impervious to suggestion and that he had demonstrated no insight into these matters.

110. The Tribunal further found that Dr Tudor had shown no insight into the inappropriateness of his prescribing and into the risks to which he subjected his patients; into his dishonesty in relation to breaching IOT orders and CQC regulations; or in relation to providing dishonest instructions to his legal representative.

111. It further noted that Dr Tudor had not displayed evidence of having had a 'damascene' moment, having attended the hearing at the impairment stage. Dr Tudor continued to attempt to justify what the Tribunal felt to be unjustifiable. Given the history of this matter, one wondered when such amount of self awareness might occur. In such circumstances, the Tribunal considered that there was a very high-risk of repetition of his misconduct.

112. The Tribunal further considered that Dr Tudor's serious misconduct breached fundamental tenets of the profession, put patient safety at risk and would be regarded as deplorable by fellow practitioners.

113. The Tribunal further determined that all four questions raised by Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry and endorsed in the *Grant* case, as stated above, were engaged in this case.

114. The Tribunal concluded that public confidence in the medical profession would be undermined and that there would be a failure to uphold professional standards if a finding of

impairment was not made. It also found that patient safety had been compromised and there were instances of dishonesty.

115. The Tribunal's view in this case was that some of the allegations of serious misconduct would have justified impairment in isolation. In any event, taken as a whole, the totality of Dr Tudor's misconduct clearly impaired his ability to practise as a doctor.

116. It noted that Dr Tudor's behaviour fell significantly below the standard to be expected from a medical practitioner.

117. The Tribunal considered that a finding of impairment was necessary 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 the profession.

118. Accordingly, the Tribunal determined that Dr Tudor's fitness to practise was impaired by reason of his misconduct.

DETERMINATION ON SANCTION – 09/01/2024

591. Having determined that Dr Tudor's fitness to practise is impaired by reason of his misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

592. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

Submissions

593. On behalf of the GMC, Ms Rollings submitted that Dr Tudor should be familiar with GMP, particularly those paragraphs concerning patient safety and public confidence. She also took the Tribunal through the relevant paragraphs of the Sanctions Guidance (SG). Ms Rollings raised concerns about Dr Tudor's lack of insight and failure to take appropriate steps towards remediation. Ms Rollings highlighted that Dr Tudor has demonstrated a dismissive

attitude towards the proceedings, a refusal to accept his mistakes, and has made inadequate efforts in respect of remediation.

594. Ms Rollings submitted that there are a number of aggravating factors in this case, such as Dr Tudor's limited insight, his failure to remediate effectively, and the seriousness of his clinical misconduct. Ms Rollings expressed concern over Dr Tudor's potential return to practice, and referred to his comments indicating he would be *"better controlled in an NHS Practice."*

595. Ms Rollings explored the mitigating factors in this case, particularly in terms of remediation. She questioned Dr Tudor's willingness to remediate and she submitted that the Tribunal should place little weight on the testimonial in light of incomplete information provided to the author by Dr Tudor.

596. Ms Rollings submitted that suspension was not appropriate, given Dr Tudor's lack of insight, repeated misconduct, and the risk of repetition. She argued that erasure from the medical register is the only suitable sanction due to Dr Tudor's persistent dishonesty, reckless disregard for professional standards, and a lack of insight.

597. Ms Rollings therefore urged the Tribunal to consider erasure as the appropriate sanction, emphasising the serious nature of Dr Tudor's proven misconduct, his lack of remediation, and the broader public interest.

598. In his reflective statement, Dr Tudor submitted that he acknowledges and takes responsibility for his various professional lapses. Regarding the prescribing of levothyroxine, Dr Tudor admitted to treating patients against the guidelines due to TSH levels being within the UK reference range. However, he noted symptom improvement and submitted that he had obtained informed consent. Dr Tudor submitted that he will not be prescribing levothyroxine against guidelines in the future.

599. Concerning methotrexate, Dr Tudor submitted that he admits prescribing it without folic acid, attributing this to an oversight on his part. Dr Tudor expressed regret and pledged not to initiate methotrexate treatment without specialist advice in the future.

600. Dr Tudor admitted prescribing controlled drugs, but submitted that this was in error and he is now committed to following NICE Guidance in the future. Dr Tudor also

acknowledged treating family members, including an exacerbation of bronchial asthma in XXX, and submitted that he regrets not referring them to their own GP.

601. Dr Tudor accepts responsibility for the delayed CQC registration of TMM and acknowledged the resulting criminal offences and fine. He submitted that there will be no repetition of this and expressed a desire to work as an NHS GP and not work in private practice again.

602. Regarding alleged dishonesty, Dr Tudor maintained that there was confusion regarding the prescriptions issued during suspension due to locum login discrepancies. Dr Tudor submitted that the Tribunal should consider his demonstrated insight and stated that there would be no repetition, emphasising his intention to continue professional development and adherence to GMP.

603. Dr Tudor submitted that he has been compliant with conditions/restrictions for over three years and he would like to continue practicing, particularly within the NHS, with supervision and colleague support.

604. In his oral submissions to the Tribunal, Dr Tudor repeated on several occasions that he had never put patents at risk and that he would never do so in the future. He denied having approached the questions of clinical guidelines in a cavalier fashion. He submitted that, when he had treated patients outside guidance, he had always considered the matter carefully, and had done so in a 'controlled fashion'. He stated that he understood that clinical guidelines were in place to protect patents and that a failure to comply with them was inappropriate. He then explained that he had 'got results' from going outside of guidelines. He had happy patients and had given treatment a lot of thought. Dr Tudor stated that nearly all of his patients had benefitted from his treatment and none had come to harm.

605. Dr Tudor further explained that he was willing to change and had been humbled by this experience. He wished to carry on as a doctor working for an NHS GP practice. He submitted that it was appropriate for him to return to restricted practice subject to conditions, including supervision. Dr Tudor suggested that he had good people skills and was a good listener.

The Relevant Legal Principles

606. The Tribunal has taken into account the Sanctions Guidance (SG) and the departures from GMP that it has found.

607. In making its decision, the Tribunal had regard to the principle of proportionality, and it had weighed Dr Tudor's interests with those of the public. Throughout its deliberations the Tribunal had borne in mind that the purpose of sanctions is not to punish a doctor, but to protect the public. It had also taken into account the overarching objective which is to protect the health, safety and wellbeing of the public, maintain public confidence in the profession, and promote and maintain proper professional standards and conduct for the members of the profession.

608. The Tribunal has also borne in mind that in deciding what sanction, if any, to impose, it should consider all the sanctions available, starting with the least restrictive and then consider each sanction in ascending order.

The Tribunal's Determination on Sanction

609. This is a serious case. This Tribunal has found proven 77 allegations which give rise to an ongoing impairment to practise medicine in Dr Tudor's case. They allegations vary in their nature and gravity. They cover a period between August 2017 and May 2020. The Tribunal accepts that in isolation some of these allegations are less serious than others. However, in the light of the chronology of this case, the Tribunal takes the view that the question of sanction can only be properly viewed in the round. The simple timeline is as a follows.

610. TMM opened in April 2017. The Tribunal has found that the surgery remained open to patients on a full-time basis until it closed in May 2020. In the meantime, the CQC received a complaint in September 2018 that TMM was operating without registration in respect of the provision of regulated medical services. In other words, TMM and Dr Tudor were not registered to see or treating patients. Dr Tudor was sent a letter explaining that he was therefore committing criminal offences.

611. CQC visited the surgery in October 2018, when its offices observed that the waiting room was full. Dr Tudor was again similarly warned about his conduct. He nonetheless continued to see and treat patients and to keep open the surgery.

612. Dr Tudor was not deterred when in April 2019, he was interviewed under the Police and Criminal Evidence Act under caution by CQC officers. The TMM surgery doors remained open.

613. In July 2019, an IOT imposed conditions which, amongst others, required Dr Tudor to cease providing medical services until he was registered. Dr Tudor persisted, notwithstanding a further IOT hearing in November 2019.

614. Matters came to a head on 6th January 2020, when Dr Tudor appeared before a further IOT hearing when there was evidence presented that he had prescribed drugs to a patient on 29th November 2019 in breach of his conditions. Dr Tudor told that IOT that this was a one off and would not be repeated. He made this representation knowing that the surgery was open on a full-time basis, and that as the only doctor in the practice, he was seeing and treating patients daily. Indeed, it was clear from the evidence before this Tribunal that Dr Tudor had seen patients on 2nd and 3rd January 2020, immediately before the hearing, and had issued a prescription on 2nd January 2020.

615. Dr Tudor has maintained that the representation to the IOT on 6th January 2020 was an unintentional error. He added in his submissions, *"I cannot explain why I instructed counsel in an IOT that the prescription was a one-off (although that statement was made to the best of my knowledge and belief at the time)… "* The Tribunal did not accept this explanation. It is satisfied that Dr Tudor lied to the IOT on that occasion, and that his repeated attempts to persuade the Tribunal otherwise (including at this stage 3 hearing) are also lies.

616. Dr Tudor told the IOT on 18th February 2020 that he had closed TMM. This was simply not true. Dr Tudor was suspended by the IOT on that occasion. However, this Tribunal is satisfied that the surgery remained open, and that Dr Tudor continued to see and treat patients. Again, this Tribunal does not accept Dr Tudor's persistent attempts to suggest otherwise, which the Tribunal treats as ongoing untruthful evidence.

617. TMM was convicted of two charges of failing to register with the CQC contrary to section 10 of the Health and Social Care Act 2008 on 6th February 2020. However, the surgery remained open until the end of May 2020. The surgery was not actually registered to provide prescriptions to patients until 24th February 2020, having opened in April 2017.

618. It is in the context of this chronology that the allegations of clinical misconduct should also be viewed. They are, in themselves serious breaches of clinical guidelines and/or GMP. But the treating of patients was unregulated by the CQC; and/or in breach of conditions imposed by GMC; and/or in flagrant disregard of the attempts of the IOTs to restrict his medical practice. In this Tribunal's view, he has shown a persistent contempt for those bodies obligated to regulate his professional conduct. The Tribunal would add that there has been evidence of this attitude persisting throughout these proceedings.

Aggravating & Mitigating Factors

619. In reaching its decision, the Tribunal considered the aggravating and mitigating factors present in this case.

620. The Tribunal referred itself to paragraphs 50-56 of the Sanctions Guidance (2020)('SG') for aggravating factors and to paragraphs 25-49 of SG for mitigating factors.

621. In relation to aggravating factors, Dr Tudor continues to take issue with the suggestion that he had been dishonest in relation to regulatory matters, when one can see from the matters set out above that there is no other viable explanation for events.

622. Further, Dr Tudor maintained even at this hearing that he had never put patients at risk. There is an obvious dichotomy between this representation, and his apparent acceptance that clinical guidelines are in place for the protection of patients. It is clear to this Tribunal that Dr Tudor views his divergences from GMP and clinical guidelines as examples 'thinking outside of the box' of which he is proud, and not as dangerous or reckless.

623. Dr Tudor repeatedly submitted that he had not harmed patients. The Tribunal makes the obvious point that whether actual harm was done to patients is a matter of chance. By failure to observe GMP and/or clinical guidelines, there is a risk created to patients. Dr Tudor found it difficult to demonstrate insight into this risk.

624. In any event, as the matters raised in the previous determinations highlight, some of Dr Tudor's patients did suffer adverse symptoms as a result of his treatment. By way of an example discussed during the stage 3 hearing, patient G was wrongly diagnosed and treated for hypothyroidism by Dr Tudor, and as a result developed symptoms of hyperthyroidism which required treatment. The Tribunal was satisfied that Dr Tudor had not spent any time critically analysing his treatment of the patient, and clearly did not accept causing her harm.

625. Accordingly, the Tribunal was satisfied that Dr Tudor had shown remarkably little evidence of insight into these matters, and that there was little prospect of his insight developing in the future.

626. In terms of mitigating factors, the Tribunal treated Dr Tudor as a man who had, prior to these matters, an unblemished professional history, and was a man of good character. However, this must be tempered by his conduct in this case, both in relation to the commission of the misconduct alleged, and his conduct of the proceedings. He is, of course, entitled to defend himself, and the Tribunal is careful not to hold this against him. However, the Tribunal determined that he had been repeatedly dishonest towards the CQC and IOTs. This Tribunal further finds that Dr Tudor was dishonest to this Tribunal during the course of these proceedings. This therefore impacts upon the Tribunal's view of his character somewhat. We also note that it is difficult to remediate dishonesty, as compared to other forms of misconduct.

627. The Tribunal notes that Dr Tudor has undertaken some CPD. However, it is the Tribunal's view that this has not been targeted to the issues in this case, and has not significantly developed Dr Tudor's understanding of his misconduct. It is the Tribunal's view that Dr Tudor does not readily accept the need for remediation of this sort, and that what has been done has been to create the impression that he is committed to remediation, rather than it being out off any genuine motivation. The Tribunal has seen very limited evidence of attempts to remediate the dishonesty matters, accepting as it does the difficulties associated with such remediation.

628. In preparation for the hearings, Dr Tudor adduced testimonials. However, the Tribunal felt it appropriate to place limited weight on these. The Tribunal felt that in the light of the nature and severity of the misconduct, such personal mitigation was likely to be of limited relevance. Further, that it was clear that the providers of the various testimonials had not always been provided with accurate information as to the nature of the allegations, or the progress of these proceedings.

629. The Tribunal accepts that Dr Tudor has made expressions of regret. However, this needs to be examined in the context of the other matters set out above. It is the Tribunal's impression of Dr Tudor that he has no clear understanding of the nature and gravity of the misconduct that this Tribunal has found. He has given limited time to thinking about his

conduct in a critical way. This is best demonstrated by his apparent failure to read either the stage 1 or stage 2 determination, notwithstanding that he seeks to represent himself.

630. GMC counsel noted that Dr Tudor was XXX. The Tribunal did not consider this to be a relevant factor when making its decision.

The Tribunal's Decision

No action

631. The Tribunal first considered whether to conclude the case by taking no action. It reminded itself that there should be exceptional circumstances to justify taking no action where a finding of impairment has been made.

632. The Tribunal considered that there were no exceptional circumstances in this case that could justify taking no action. The Tribunal further determined that it would be neither sufficient nor proportionate to conclude this case by taking no action.

Conditions

633. The Tribunal then considered whether imposing an order of conditions on Dr Tudor's registration would be appropriate. It was Dr Tudor's submission that it was appropriate for him to return to restricted practice subject to conditions, including supervision. The Tribunal bore in mind that any conditions imposed should be appropriate, proportionate, workable and measurable. It had regard to paragraphs 81 and 82 of the SG which indicate the cases in which conditions might be appropriate.

> *'81 Conditions might be most appropriate in cases:*
>
> *a) involving the doctor's health*
>
> *b) involving issues around the doctor's performance*
>
> *c) where there is evidence of shortcomings in a specific area or areas of the doctor's practice*
>
> *d) where a doctor lacks the necessary knowledge of English to practise medicine without direct supervision.*
>
> *82 Conditions are likely to be workable where:*
>
> *a the doctor has insight*

b a period of retraining and/or supervision is likely to be the most appropriate way of addressing any findings
c the tribunal is satisfied the doctor will comply with them
d the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised..'

634. The Tribunal considered that paragraphs 81 and 82 did not apply in this case. Primarily, the Tribunal has already found that Dr Tudor lacked any insight. It also bore in mind that the history of this case was littered with examples of Dr Tudor flouting attempts to regulate and/or apply conditions to his medical practice. The Tribunal was satisfied that Dr Tudor was unlikely to comply with the sort of conditions that might be imposed in this type of case. Moreover, the Tribunal determined that an order of conditions would not be appropriate, workable or proportionate to address the scale of the misconduct.

Suspension

635. The Tribunal went on to consider whether a period of suspension would be appropriate. It considered the following paragraphs of the SG:

"91 Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.

92 Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).

93 Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a) A serious breach of Good Medical Practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

…

e) No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f) No evidence of repetition of similar behaviour since incident.

g) The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.

120 Good medical practice states that registered doctors must be honest and trustworthy, and must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession."

636. The Tribunal considered this is the first time Dr Tudor's fitness to practise has been found impaired. It had regard to the lack of evidence of remediation at the previous stages of the hearing and the lack of evidence of it having developed since the hearing began. The Tribunal considered that the SG indicated that an absence of evidence of meaningful insight or remediation indicated that suspension was not appropriate. It noted that the allegations covered a significant period of time and represented repeated and ingrained standards of behaviour, which together with a lack of evidence of insight or remediation, was suggestive of a likelihood of repetition in the future.

637. In addition, the Tribunal determined that a further period of suspension would be insufficient to maintain and uphold proper professional standards and protect the public confidence in the profession. It also determined that suspension would not mark the seriousness of the misconduct or send a proportionate signal to Dr Tudor regarding the gravity of the findings against him.

Erasure

638. In reaching its determination, the Tribunal considered the following paragraphs of the SG:

> *'108 Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.*
>
> *109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> *b A deliberate or reckless disregard for the principles set out in good medical practice and/or patient safety.*
>
> *h Dishonesty, especially where persistent and/or covered up…*
>
> *j Persistent lack of insight into the seriousness of their actions or the consequences.'*

639. The Tribunal considered that all of the above paragraphs of the SG are engaged in this case.

640. The Tribunal took account of Dr Tudor's dishonesty, which as already stated, has been enduring and in the face of this Tribunal. Furthermore, the Tribunal is satisfied that some of his dishonesty was with the intention of concealing to the IOT's that TMM remained open and that Dr Tudor continued to provide regulated medical services which he was not permitted to do so in the circumstances.

641. The Tribunal noted Dr Tudor has been given ample time and opportunity to produce evidence of insight and remediation but had failed to do so. Notwithstanding that the Tribunal had, at the stage 2 determination, criticised Dr Tudor's attempts at remediation, he had produced little new information at the stage 3 hearing. At the stage 3 hearing, it was

apparent that he had given very limited thought to the matters of dishonesty, or to issues relating to the protection of the reputation of the medical profession, or to the maintenance of professional standards. There was no basis or evidence upon which the Tribunal could conclude that Dr Tudor would be prepared to engage in any meaningful remediation or that any such engagement would be successful.

642. The Tribunal determined that Dr Tudor's conduct (the 77 allegations found proved and which amounted to serious misconduct) were all examples of particularly serious departures from the principles set out in GMP. As a consequence, it took the view that his misconduct was fundamentally incompatible with continued registration. In particular, the Tribunal was of the view that being honest with their professional regulator is the responsibility of every doctor. It is an important part of upholding professional standards, so that the public could have confidence in all doctors.

643. The Tribunal was mindful of the principle of proportionality. It recognised that erasing Dr Tudor's name from the medical register means that he will no longer be able to practise medicine. In all the circumstances, the Tribunal reached the conclusion that erasure was an appropriate and proportionate sanction. The Tribunal determined that erasure was the only sanction that would be sufficient to uphold the statutory overarching objective, to protect patients, maintain public confidence in the profession, and uphold professional standards.

DETERMINATION ON IMMEDIATE ORDER – 09/01/2024

644. Having determined that Dr Tudor's name be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Tudor's registration should be subject to an immediate order.

Submissions

645. On behalf of the GMC, Ms Rollings submitted that the GMC does not seek an immediate order as the interim order of suspension currently in place can run until the substantive sanction of erasure is imposed.

646. Dr Tudor submitted that he has no intention of practising as a doctor in the time between the hearing and the sanction of erasure being imposed and therefore an immediate was not necessary.

The Tribunal's Determination

647. The Tribunal has taken account of the relevant paragraphs of the SG, in particular paragraphs 172, 173 and 178 as set out below:

> *"172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor…*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect."*

648. The Tribunal concluded, that given its findings at the impairment and sanction stage, that public confidence in the profession would be not affected if an immediate order was not imposed as he was currently suspended. It bore in mind that Dr Tudor has not been working for a significant period of time and the suspension is in place until 11 March 2024 which would be sufficient protection for the public in the circumstances.

649. Accordingly, the Tribunal determined that an immediate order was not required as the interim order will remain in place until the substantive sanction of erasure is imposed.

650. This means that Dr Tudor's registration will be erased 28 days from the date on which written notification of this decision is deemed to have been served upon him, unless he lodges an appeal.

651. That concludes this case.

ANNEX A – 02/02/2023

Service

1. Dr Tudor is not present today at this Medical Practitioners Tribunal ('MPT') hearing. The Tribunal therefore considered whether the relevant documents had been served in accordance with Rule 40 of the General Medical Council ('GMC') ('Fitness to Practise') Rules 2004 ('the Rules') and paragraph 8 of the fourth Schedule to the Medical Act 1983.

2. Mr Boyd Morwood, Counsel, on behalf of the GMC, provided the Tribunal with various documents regarding service of the Notice of the Hearing of Dr Tudor. This included:

- Screenshot of Dr Tudor's registered address and email, undated;
- Notice of Allegation sent from the GMC to Dr Tudor, via email, dated 3 August 2022;
- Proof of Service for the Notice of Allegation, sent via email, dated 8 August 2022;
- Notice of Hearing sent from the MPTS to Dr Tudor, via email, dated 8 November 2022;
- Proof of Service for the Notice of Hearing, sent via email, dated 8 November 2022;
- Email from Dr Tudor's legal representative, dated 9 December 2022;
- Email from Dr Tudor to the GMC, dated 16 December 2022;
- Email from Dr Tudor's solicitor to the GMC, dated 9 January 2023.

3. Mr Morwood submitted that service has been effected in accordance with the rules and that Dr Tudor is aware that the hearing is due to take place as evidenced by the emails from his solicitor to the GMC dated 9 December 2022 and 9 January 2023.

4. The Tribunal had regard to the documents before it and the submissions made by Mr Morwood. It was satisfied that notice of this hearing had been served in accordance with Rule 40.

Proceeding in Absence

5. Satisfied that notice was properly served upon Dr Tudor, the Tribunal then considered whether to proceed with this hearing in his absence, in accordance with Rule 31 of the Rules.

6. Mr Morwood submitted that since the Rule 7 response from Dr Tudor, he has disengaged from the process. He referred the Tribunal to the emails from Dr Tudor's solicitor to the GMC dated 9 December 2022 and 9 January 2023, which state, respectively:

> *"I've been awaiting confirmation of my client's instructions further to a conference with Counsel earlier this week. I can now confirm that our instructions are as follows:*

- *Dr Tudor will not be serving expert evidence;*
- *He will not be attending the MPT hearing;*
- *He intends to submit an application for voluntary erasure XXX.*

I will be updating the MPTS in the above terms shortly. At this juncture I do not expect that any defence evidence will be served; or that we will be instructed in relation to the hearing."

"I confirm as follows:

a. Dr Tudor is content for the matter to proceed in his absence;
b. He does not object to the records in relation to Patient P being relied upon at the hearing."

7. Mr Morwood submitted that Dr Tudor did not make any disclosure of evidence by the deadline of 25 November 2022 as set out in the directions, and that he had disengaged from the process since the Rule 7 response stage. He submitted that Dr Tudor has a solicitor who he had instructed to inform the MPTS that he would not be attending these proceedings.

8. In respect of the voluntary erasure application referenced in the email from the solicitor, Mr Morwood said that this application was partly influenced by XXX. However, Dr Tudor had not engaged other than at the Rule 7 stage, that he had instructed a solicitor but had not requested an adjournment, nor requested the Tribunal to consider a further voluntary erasure application. Mr Morwood submitted that the emails from the solicitor effectively state that Dr Tudor is content for the hearing to proceed in his absence.

The Tribunal's decision

9. The Tribunal was conscious that in accordance with the principles in *R v Jones (2001) EWCA Crim 168* and *Adeogba (2016) EWCA Civ 162*, the discretion to proceed in the absence of a doctor should be exercised with the utmost care and caution, balancing the interests of the doctor with the wider public interest.

10. The Tribunal had before it evidence that Dr Tudor was aware of the hearing commencing on 9 January 2023. It noted that Dr Tudor had legal representation, and had pursued a voluntary erasure application immediately prior to the commencement of these proceedings, which the GMC had refused.

11. The Tribunal considered the XXX in respect of the voluntary erasure application. It noted that there was evidence before it that Dr Tudor would be XXX. These XXX were only put forward in respect of the voluntary erasure application and were not put forward to this Tribunal as a reason for adjourning these proceedings.

12. The Tribunal determined that Dr Tudor had chosen to voluntarily absent himself from the hearing. Furthermore, it has not received any indication that Dr Tudor had requested an adjournment in order to engage at a later date. The Tribunal could not therefore be satisfied that, were there to be an adjournment, Dr Tudor would engage with proceedings at any later date.

13. The Tribunal concluded that it was in the public interest and in the interests of justice to proceed with this hearing today.

14. Accordingly, the Tribunal determined that it was fair and reasonable to proceed in Dr Tudor's absence.

ANNEX B – 02/02/2023

Application to amend the Allegation

1. Throughout the proceedings a number of typographical errors or omissions within the Allegation were identified by the Tribunal and by Mr Morwood. It was agreed that these would be addressed during Mr Morwood's closing submission at Stage 1.

2. On day 8 of the hearing, at the end of Mr Morwood's Stage 1 submission, Mr Morwood proposed the following amendments to the Allegation be made:

Paragraph13a

13. You prescribed and/or administered a Cosmofer injection for Patient E when this was not clinically indicated on:

a. ~~16~~13 June 2018

Paragraph17

17. On 22 February 2019 you consulted with Patient G and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism despite Patient G's blood results indicating a normal ~~forward~~ thyroid function.

Paragraph 21a

21. On 22 February 2019 you consulted with Patient H and you failed to:

a. make an appropriate diagnosis in that you diagnosed hypothyroidism without any blood results ~~despite Patient E's blood results indicating a normal thyroid function~~;

Paragraph 24aiii

24. On one or more of the dates set out in Schedule 7 you failed to:

a. prescribe appropriately for Patient I in that you prescribed Methotrexate:

iii. at a higher dose ~~bond~~ band than is advised in the BNF guidance:

Paragraphs 33bii & 33cii

33. On 8 March 2018 you consulted with Patient L and you failed to:

b. prescribe appropriately in that you prescribed:

ii. a ~~Beclemtasome~~ Beclometasone inhaler when ~~Beclemtasome~~ Beclometasone was an unlicensed treatment for someone of Patient L's age; To be determined

c. obtain informed consent from Patient L's parents:

ii. for the prescription of a ~~Beclemtasome~~ Beclometasone inhaler in that you did not inform Patient L's parents that the prescription was

Paragraph 35a

35. On 14 May 2020 you consulted with Patient N and you failed to:

a. prescribe appropriately in that you prescribed Clopidogrel 75mg daily for anti-phospholipid syndrome

3. The Tribunal was satisfied that the proposed amendments were corrective rather than material to the Allegation and that there would be no injustice to Dr Tudor in allowing the application to amend on each occasion. The Tribunal therefore determined to grant the application pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules').

Paragraph 11

4. The Tribunal invited Mr Morwood's to make any comments that he may have in respect to the proposed amendments to paragraph 11 of the Allegation:

Paragraph 11

11. On 14 April 2018 you consulted with Patient E and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism without any blood results ~~despite Patient E's blood results indicating a normal thyroid function~~.

5. Mr Morwood advised the Tribunal that he would like to take instructions on the matter and that he would be proposing an alternative amendment to these paragraphs.

6. At the outset of day 9 of the hearing, Mr Morwood invited the Tribunal to consider the following proposed amendment to paragraph 11:

"11. On 14 April 2018 you consulted with Patient E and you failed to make an appropriate diagnosis in that you diagnosed hypothyroidism either:

a despite Patient E's blood results indicating a normal thyroid function or

b without blood results.

The GMC believe that 11a would cover a finding that Dr Tudor had readings but paid no regard to them but if the panel is minded not to accept that proposition a further proposed amendment to the charges would be proposed to read:

c with no regard to the available blood results."

7. Mr Morwood confirmed, following a question from the Legally Qualified Chair, that the GMC were proposing to amend this paragraph of the Allegation in respect of 11a and b as set out above (not sub paragraph c).

8. The Tribunal was satisfied that the proposed amendment in respect of 11a and b (not c) were corrective rather than material to the Allegation and that there would be no injustice to Dr Tudor in granting making them. The Tribunal therefore determined to grant to the application pursuant to Rule 17(6) of the Rules.

ANNEX C– 02/02/2023

Decision to adjourn XXX

Adjournment

1. On day 19 of the hearing, having handed down its Stage 1 decision on facts, and with one day remaining in the listing, the Tribunal decided that there was insufficient time to conclude matters in this case. It determined to adjourn subject to Rule 29(2) of the General

Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), until 7- 18 August 2023 to conclude.

XXX

Schedule 1

DATE	PRESCRIPTION
2 August 2017	Levothyroxine 25mcg
16 August 2017	Levothyroxine 100mcg
15 November 2017	Levothyroxine 125mcg
12 December 2017	Levothyroxine 150mcg
3 July 2019	Repeat prescription issued
31 July 2019	Repeat prescription issued
30 August 2019	Repeat prescription issued
22 October 2019	Repeat prescription issued
19 November 2019	Repeat prescription issued
10 December 2019	Repeat prescription issued
2 January 2020	Repeat prescription issued
10 February 2020	Repeat prescription issued
2 March 2020	Repeat prescription issued
16 April 2020	Repeat prescription issued
18 May 2020	Repeat prescription issued

Schedule 2

DATE	PRESCRIPTION
18 May 2019	Methorexate 12.5mg once per week
6 June 2019	Methorexate 2.5mg tabs x 20
3 July 2019	Repeat prescription issued
31 July 2019	Repeat prescription issued

Schedule 3

DATE	PRESCRIPTION
2 February 2018	Levothyroxine 25mcg
8 June 2018	Levothyroxine 25mcg
31 July 2018	Levothyroxine 50mcg
3 October 2018	Levothyroxine 100mcg
18 January 2019	Levothyroxine 100mcg
20 February 2019	Levothyroxine 125mcg
26 March 2019	Levothyroxine 100mcg
1 May 2019	Levothyroxine 100mcg
3 July 2019	Repeat prescription issued
31 July 2019	Repeat prescription issued
18 September 2019	Levothyroxine 100mcg
2 November 2019	Repeat prescription issued
17 January 2020	Levothyroxine 150mcg
2 March 2020	Repeat prescription issued
26 March 2020	Repeat prescription issued

Schedule 4

DATE	PRESCRIPTION
31 July 2018	Diazepam 5mg x 100
3 October 2018	Diazepam 5mg x 100
18 January 2019	Diazepam 5mg x 100
1 May 2019	Diazepam 5mg x 90
3 July 2019	Repeat prescription issued
31 July 2019	Repeat prescription issued
18 September 2019	Diazepam 5mg x 100
28 September 2019	Replacement prescription for Diazepam 5mg x 100
2 November 2019	Repeat prescription issued
17 January 2020	Diazepam 5mg x 60
19 May 2020	Diazepam 5mg

Schedule 5

DATE	PRESCRIPTION
14 April 2018	Levothyroxine 25mcg
28 April 2018	Levothyroxine 50mcg
11 May 2018	Levothyroxine 50mcg
29 May 2018	Levothyroxine 50mcg
13 June 2018	Levothyroxine 75mcg
10 July 2018	Levothyroxine 50mcg
28 July 2018	Repeat prescription issued
18 August 2018	Levothyroxine 100mcg

6 November 2018	Levothyroxine 100mcg
6 February 2019	Levothyroxine 100mcg
4 March 2019	Levothyroxine 50mcg
21 March 2019	Levothyroxine 100mcg
23 April 2019	Levothyroxine 125mcg
11 June 2019	Levothyroxine 100mcg

Schedule 6

DATE	PRESCRIPTION
14 July 2018	Levothyroxine 25mcg
18 July 2018	Levothyroxine 25mcg
15 August 2018	Levothyroxine 50mcg
29 August 2018	Levothyroxine 100mcg
26 September 2018	Levothyroxine 125mcg
19 October 2018	Levothyroxine 100mcg
24 October 2018	Levothyroxine 125mcg
21 November 2018	Repeat prescription issued
11 December 2018	Repeat prescription issued
8 January 2019	Levothyroxine 150mcg
15 January 2019	Levothyroxine 150mcg
6 February 2019	Levothyroxine 75mcg
16 April 2019	Levothyroxine 75mcg
15 May 2019	Levothyroxine 75mcg
1 August 2019	Repeat prescription issued

27 August 2019	Levothyroxine 50mcg
26 September 2019	Levothyroxine 75mcg
25 October 2019	Levothyroxine 25mcg
7 November 2019	Levothyroxine 25mcg
6 December 2019	Levothyroxine 25mcg

Schedule 7

DATE	PRESCRIPTION
24 September 2019	Methotrexate 12.5mg
10 October 2019	Repeat prescription issued
6 November 2019	Repeat prescription issued

Schedule 8

DATES OF CONSULTATIONS	TREATMENT/CARE PROVIDED
29 November 2017	History taken Examination performed Diagnosis made Otomize spray prescribed
8 December 2017	History taken Advice given Citalopram 20mg x 30 prescribed
3 January 2018	History taken Citalopram 10mg x 100 prescribed
10 February 2018	History taken Advice given
25 April 2018	Diagnosis made Otomize 10mls prescribed Amoxiclav 500/125 x 21 prescribed

24 July 2018	History taken
25 July 2018	B12 left deltoid prescribed and administered
19 January 2019	Diagnosis made Dovonex 50mcg ointment prescribed
2 May 2019	History taken Examination performed Diagnosis made Omeprazole 20mg x 60 prescribed
11 June 2019	History taken Diagnosis made Advice given Kenalog 40mg injection prescribed and administered

Schedule 9

DATES OF CONSULTATIONS	TREATMENT/CARE PROVIDED
3 November 2017	Diagnosis made Phenergan 5mg & Erythromycin 250mg prescribed
4 November 2017	Amoxicillin 125mg prescribed
16 October 2018	History taken Examination performed Diagnosis made Co-amoxiclav 125/31mg and Salbutamol inhaler prescribed
21 November 2018	History taken Examination performed Diagnosis made Advice given Beclomethasone 50mcg prescribed
27 June 2019	Diagnosis made Erythroped suspension 250mg/5mls & Phenergan 5mg/5ls prescribed

Schedule 10

Oxazepam 10mg x 42

Zopiclone 7.5mg x 7

Codeine 30mg x 56

Schedule 11

DATE	ACTION AMOUNTING TO BREACH	CONDITIONS BREACHED
30 July 2019	Consulted with Patient P at TMM and issued a prescription for Mirtazapine	Condition 1
31 July 2019	Issued a repeat prescription for Patient C from TMM to include Levothyroxine and diazepam	Condition 1 Condition 2 Condition 3
31 July 2019	Consulted with Patient A at TMM & issued a repeat prescription to include Levothyroxine and morphine sulphate	Condition 1
1 August 2019	Consulted with Patient G at TMM and issued a repeat prescription to include Levothyroxine	Condition 1
27 August 2019	Consulted with Patient G at TMM and issued a repeat prescription for Allopurinol and Levothyroxine	Condition 1
27 August 2019	Consulted with Patient P and issued a prescription for Citalopram and Atorvastatin	Condition 1
30 August 2019	Consulted with Patient A at TMM & issued a repeat prescription to include Levothyroxine and morphine sulphate	Condition 1 Condition 2
10 September 2019	Consulted with Patient I at TMM	Condition 1

12 September 2019	Consulted with Patient I at TMM and issued a prescription for Levothyroxine, Celecoxib and Omeprazole	Condition 1
17 September 2019	Issued a prescription for Patient I from TMM	Condition 1
13 September 2019	Consulted with Patient Q at TMM and issued a prescription for Levothyroxine	Condition 1
18 September 2019	Issued a repeat prescription for Patient C from TMM to include Levothyroxine and diazepam	Condition 1 Condition 2 Condition 3
20 September 2019	Consulted with Patient P and issued a repeat prescription for Citalopram and Atorvastatin	Condition 1
24 September 2019	Consulted with Patient I at TMM and issued a prescription for Methotrexate	Condition 1
25 September 2019	Consulted with Patient A at TMM and issued a prescription for Nystatin and Co-amoxiclav	Condition 1 Condition 2
26 September 2019	Consulted with Patient G at TMM and issued a prescription for Levothyroxine, Celecoxib, Omeprazole and Folic acid	Condition 1
28 September 2019	Issued a replacement prescription for Patient C from TMM to include diazepam	Condition 1 Condition 2
9 October 2019	Issued a prescription for Levothyroxine for Patient F	Condition 1 Condition 3
10 October 2019	Consulted with Patient I at TMM and issued a repeat prescription for all meds	Condition 1
22 October 2019	Consulted with Patient A at TMM & issued a repeat prescription to include	Condition 1 Condition 2

	Levothyroxine and morphine sulphate	
24 October 2019	Consulted with Patient P at TMM and issued a prescription for Citalopram and Zolpidem	Condition 1 Condition 2
25 October 2019	Consulted with Patient G at TMM and issued prescription for Mesalazine, Allopurinol and Levothyroxine	Condition 1
1 November 2019	Issued a prescription for Levothyroxine for Patient F	Condition 1 Condition 3
2 November 2019	Undertook telephone consultation from TMM with Patient C & issued a repeat prescription to include Levothyroxine and diazepam	Condition 1 Condition 3
6 November 2019	Consulted with Patient I at TMM and issued repeat prescription for Mesalazine, Allopurinol and Levothyroxine	Condition 1
7 November 2019	Consulted with Patient G at TMM and issued prescription for Mersalasine, Allopurinol and Levothyroxine	Condition 1
6 December 2019	Consulted with Patient G at TMM and prescribed Allopurinol, Levothyroxine and Mersalasine.	Condition 4
19 November 2019	Issued a repeat prescription for Patient A to include Levothyroxine and morphine sulphate	Condition 2 Condition 3 Condition 4
26 November 2019	Issued a prescription for Patient O	Condition 4
10 December 2019	Consulted with Patient A at TMM & issued a repeat prescription to include Levothyroxine and morphine sulphate	Condition 2 Condition 4

2 January 2020	Consulted with Patient A at TMM & issued a repeat prescription to include Levothyroxine and morphine sulphate	Condition 2 Condition 4
2 January 2020	Issued a repeat prescription for Patient P for Atorvastin and Zolpidem	Condition 2 Condition 4
3 January 2020	Consulted with Patient C at TMM and prescribed Ciprofloxacin	Condition 4
17 January 2020	Consulted with Patient C at TMM and issued a prescription to include Levothyroxine and diazepam	Condition 2 Condition 5 Condition 6
17 January 2020	Consulted with Patient R and issued a prescription for Co-amoxiclav and Zolpidem	Condition 2 Condition 6
24 January 2020	Issued replacement prescription for Co-amoxiclav	Condition 6
27 January 2020	Issued a repeat prescription for Patient P for Atorvastin and Zolpidem	Condition 2 Condition 6
10 February 2020	Consulted with Patient A at TMM and issued a repeat prescription for all meds	Condition 2 Condition 5 Condition 6
14 February 2020	Consulted with Patient R and issued repeat prescription of Zolpidem	Condition 2 Condition 6
5 May 2020	Issued a repeat prescription for Patient A to include Levothyroxine and morphine sulphate	Condition 2 Condition 5
26 May 2020	Issued repeat prescription of Zolpidem for Patient R	Condition 2
26 May 2020	Issued repeat prescription for Patient P for Atorvastatin, Citalopram and Zolpiden	Condition 2

Schedule 12

DATE	ACTION
2 March 2020	Issued a repeat prescription for Patient C Issued a repeat prescription for Patient A Issued a repeat prescription for Patient P
3 March 2020	Issued a repeat prescription for Patient C
10 March 2020	Issued a repeat prescription for Patient R
16 March 2020	Issued a repeat prescription for Patient A Made a referral for Patient A to a Consultant Rheumatologist
23 March 2020	Issued a repeat prescription for Patient R
26 March 2020	Issued a repeat prescription for Patient C Issued a repeat prescription for Patient A
16 April 2020	Issued a repeat prescription for Patient A
23 April 2020	Issued a repeat prescription for Patient P
28 March 2020	Issued a repeat prescription for Patient R
5 May 2020	Issued a repeat prescription for Patient A