PUBLIC RECORD

Dates: 17/10/2022 - 26/10/2022

Medical Practitioner's name:	Dr Peter PETERS
GMC reference number:	4567888
Primary medical qualification:	MB BS 1987 Lagos

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

Summary of outcome

Erasure

Immediate order imposed

Tribunal:

Legally Qualified Chair	Mr Malcolm Dodds
Lay Tribunal Member:	Mr Colin Sturgeon
Medical Tribunal Member:	Dr Jonathan Davies

Tribunal Clerk:	Ms Angela Carney

Attendance and Representation:

Medical Practitioner:	Not present and not represented
Medical Practitioner's Representative:	N/A
GMC Representative:	Mr Simon Jackson, KC

Attendance of Press / Public

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

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 THE FACTS – 24/10/2022

Background

1. Dr Peters qualified as a doctor in 1987. At the time of the events Dr Peters was practising within NHS as a locum staff grade doctor in adult psychiatry, lastly working in the 'Barnet Memory Service' at Edgware Community Hospital of the Barnet, Enfield and Haringey NHS Trust, between 14 March 2022 and 14 October 2022, on which later date he resigned. Prior to that Dr Peters worked as a Staff Grade in general adult psychiatry at the Berrywood Hospital for the for Northamptonshire Healthcare NHS Foundation Trust from May 2019 to April 2020 and June 2020 to March 2022.

2. The Allegation against Dr Peters relates solely to his practice of issuing private prescriptions whilst working for The Provider Services Partnership. The Provider Services Partnership provides clinical reviews for overseas patients who were not registered with a GP in the UK. It is alleged that Dr Peters inappropriately prescribed medication to a number of patients and failed to take reasonable steps to contact the clinician who had previously prescribed for the patients. It is further alleged that Dr Peters failed to ensure he had the appropriate registration for prescribing to patients in Egypt and indemnity insurance to do so.

3. The initial concerns were raised with the GMC by Janssen Cilag Limited via the Medicines and Healthcare products Regulatory Agency (MHRA) on 18 May 2020. Janssen Cilag Limited received orders for Xeplion 150mg pre-filled syringe doses from JP Pharmacy in Watford from prescriptions signed by Dr Peters.

The Outcome of Applications Made during the Facts Stage

4. The Tribunal granted the GMC's application, made pursuant to Rules 20 and 40 of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that, service had been effected and to proceed in Dr Peters' absence. The Tribunal's full decision on the application is included at Annex A.

5. The Tribunal granted the GMC's application, made pursuant to Rules 17(6) and 34(1) of the Rules, to amend the Allegation and adduce further evidence. The Tribunal's full decision on the application is included at Annex B.

The Allegation

6. The Allegation containing amendments granted under Rule 17(6) against Dr Peters is as follows:

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

Patients A-P

1. Between 6 August 2019 and 29 November 2019 you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that:

a. before prescribing, you failed to assess the patient(s) at all;

Amended under Rule 17(6)

Mimpara

b. in respect of Patients A-I, you prescribed Mimpara, and you:

~~i. Mimpara and you failed to:~~

i. did so outside the limits of your competence without conferring with the relevant specialists;

ii. failed to, before prescribing, establish the relevant patient's:

1. blood pressure;

2. pulse rate;

3. heart sounds;

4. most recent ECG test result;

5. most recent blood test result for:

i. serum calcium levels;

ii. parathyroid hormone levels;

iii. failed to arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1bii1-5 above;

~~1. first obtain the patient's:~~

~~i. blood pressure;~~

~~ii. pulse rate;~~

~~iii. heart sounds;~~

~~2. first assess an ECG result for the patient;~~

~~3. arrange monitoring of the patient's:~~

~~i. serum calcium;~~

~~ii. parathyroid hormone levels;~~

~~b. in respect of Patients A-C and I, you:~~

~~i. prescribed outside of your expertise;~~

~~ii. failed to document your reasons for initiating treatment with Mimpara;~~

Celsentri

c. you prescribed Celsentri and failed to:

i. obtain, before prescribing, a recent white cell count/viral load result for the patient;

ii. arrange for the prompt follow up monitoring of the patient's white cell count/viral load;

iii. have contact and guidance from specialist HIV services when prescribing Celsentri;

iv. check for drug interactions;

v. liaise with HIV services to ensure the patient had follow up and monitoring;

~~c. you prescribed:~~

~~i. Celsentri and failed to:~~

~~1. first assess a recent white cell count/viral load result for the patient;~~

~~2. have contact and guidance from HIV services when prescribing Celsentri;~~

~~3. check for drug interactions;~~

~~4. liaise with HIV services to ensure the patient had follow-up and monitoring;~~

Xeplion

d. you prescribed Xeplion and failed to:

i. establish, before prescribing, the relevant patient's:

1. blood pressure;

2. pulse rate;

3. heart sounds;

4. height;

5. weight;

6. ECG;

ii. arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1di;

iii. ascertain the mental state of the patient before prescribing;

iv. check for drug interactions;

v. review the patient's recent metabolic status;

vi. record any handover to the patient's usual treating clinician(s);

e. you prescribed Celsentri and Xeplion together, without arranging for the monitoring of any side effects.

~~ii. Xeplion and failed to:~~

~~1. first obtain the patient's:~~

~~i. blood pressure;~~

~~ii. pulse rate;~~

~~iii. heart sounds;~~

~~iv. height;~~

~~v. weight;~~

~~2. first assess an ECG result for the patient;~~

~~3. first assess the mental state of the patient;~~

~~4. check for drug interactions;~~

~~5. review the patient's metabolic status;~~

~~6. record any handover to the patient's usual treating clinician(s).~~

~~iii. Celsentri and Xeplion together without arranging monitoring of side effects~~

2. Your record keeping was inadequate in that:

a. (in the alternative to paragraph 1bii-1biii) when prescribing Mimpara to Patients A-I, as described in Schedule 1, you failed to record having undertaken the actions referred to in paragraph 1bii-1biii;

b. when prescribing to Patients A-P as described in Schedule 1, you failed to record:

i. (in the alternative to paragraph 1a) an adequate assessment of the patient;

ii. (in the alternative to paragraph 1c-e) having adequately undertaken the actions referred to in paragraph 1c-e;

c. in respect of Patient I, you failed to document your reasons for initiating treatment with Mimpara.

~~2. In the alternative to paragraph 1, your record keeping was inadequate in that when prescribing:~~

~~a. Mimpara to Patients A-I as described in Schedule 1, you failed to record having undertaken the actions referred to in paragraph 1b;~~

~~b. to Patients A-P as described in Schedule 1, you failed to record:~~

~~i. an adequate assessment of the patient;~~

~~ii. having adequately undertaken the actions referred to in paragraph 1d.~~

Patient Q

3. On or around 2 April 2020 you consulted with Patient Q and you inadequately prescribed the medication described in Schedule 2 in that:

a. before prescribing you failed to:

i. verify Patient Q's identity;

ii. obtain consent to:

1. access Patient Q's medical records;

2. treat Patient Q;

iii. take an appropriate history in that you did not make an adequate enquiry about Patient Q's:

1. presenting complaint;

2. psychiatric history;

3. medical history;

4. background history;

5. timing of depot medication to determine whether Patient Q had relapsed with medication in their system;

6. previous blood transfusion;

7. possible use of:

i. alternative remedies;

ii. alcohol;

iii. illegal substances;

iv. other medications obtained online;

iv. conduct an adequate risk assessment of Patient Q;

v. assess:

1. whether Patient Q was vulnerable;

2. Patient Q's capacity to consent;

vi. contact the following professionals involved in Patient Q's care in the patient's country of residence to verify the patient's clinical history:

1. GP;

2. mental health specialist;

3. HIV specialists;

vii. discuss alternative treatment options with Patient Q;

viii. tell Patient Q:

1. that it would be unsafe to prescribe without receiving corroborative information about treatment and follow up in Patient Q's own country of residence;

2. whether your licence to practice and prescribe within Egypt was valid;

b. you failed to:

i. liaise with HIV services to ensure Patient Q had follow-up and monitoring;

ii. record:

1. (in the alternative to paragraphs 3a and 3bi) having undertaken the actions described at paragraphs 3a and 3bi;

2. Patient Q's mental state examination;

3. where the referral for Patient Q originated;

4. your rationale for accepting Patient Q's referral;

5. your reasons for prescribing the medication set out in Schedule 2.

Patient R

4. On or around 3 April 2020 you consulted with Patient R and you and you inadequately prescribed the medication described in Schedule 3 in that:

a. before prescribing you failed to:

i. verify Patient R's identity;

ii. obtain consent to:

1. access Patient R's medical records;

2. treat Patient R;

iii. take an appropriate history in that you did not make an adequate enquiry about Patient R's:

1. presenting complaint;

2. psychiatric history;

3. medical history;

4. background history;

5. timing of depot medication to determine whether Patient R had relapsed with medication in their system;

6. possible use of:

i. alternative remedies;

ii. alcohol;

iii. illegal substances;

iv. other medications obtained online;

iv. conduct an adequate risk assessment of Patient R;

v. assess:

1. whether Patient R was vulnerable;

2. Patient R's capacity to consent;

vi. contact the following professionals involved in Patient R's care in the patient's country of residence to verify the clinical history:

1. GP;

2. mental health specialist;

3. HIV specialists;

vii. discuss alternative treatment options with Patient R;

viii. tell Patient R:

1. that it would be unsafe to prescribe without receiving corroborative information about treatment and follow up in Patient R's own country of residence;

2. whether your licence to practise and prescribe within Egypt was valid;

b. you failed to:

i. liaise with HIV services to ensure Patient R had follow up and monitoring;

ii. record:

1. (in the alternative to paragraphs 4a and 4bi) having undertaken the actions described at paragraphs 4a and 4bi;

2. Patient R's mental state examination;

3. where the referral for Patient R originated;

4. your rationale for accepting Patient R's referral;

5. your reasons for prescribing the medication set out in Schedule 3.

All patients

5. When prescribing Celsentri to Patients A-R as described in Schedules 1-3, you did so outside the limits of your competence

~~5.~~6. Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to:

a. take reasonable steps to contact the clinician who had previously prescribed to Patients A-R, Dr S, in order to ascertain whether the medication you were prescribing was necessary and appropriate;

b. check the Care and Quality Commission status of Dr S's clinical practice;

c. ensure you had the appropriate:

i. registration for prescribing to patients in Egypt;

ii. indemnity insurance to do so.

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

The Facts to be Determined

7. The Tribunal is required to determine whether Dr Peters inappropriately prescribed medication to a number of patients and failed to take reasonable steps to contact the clinician(s) who had previously prescribed for the patients. It is further alleged that Dr Peters failed to ensure he had the appropriate registration for prescribing to patients in Egypt and indemnity insurance to do so. It is further alleged that Dr Peters failed to ensure any follow up and monitoring.

Witness Evidence

8. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Dr S, former General Practitioner

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

- Mr A, Customer Service Executive, Janssen Pharmaceuticals

- Mr B, Head of Customer Services, Janssen Pharmaceuticals
- Ms C, Head of Registration Enquiries at the GMC
- Mr D, Pharmacist, Daystar Pharmacy

10. Dr Peters provided his own witness statements dated 24 July 2022.

Expert Witness Evidence

11. The Tribunal also received evidence from GMC's expert witness, Dr E, Consultant Psychiatrist. Dr E provided reports dated 19 May 2021 and 4 April 2022, 18 August 2022 and 14 October 2022.

Documentary Evidence

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

- Prescriptions from Daystar Pharmacy and J P Pharmacy, received by Janssen-Cilag 15 July 2019 – 22 April 2020
- Prescriptions from Daystar Pharmacy and J P Pharmacy, received by Janssen-Cilag 6 August 2019 – 29 November 2019 (Covered)
- Orders from Daystar Pharmacy to Janssen-Cilag for Xeplion 150mg, 22 November 2019, 13 January 2020 and 15 January 2020
- Referral from Medicines and Healthcare Products Regulatory Authority to the GMC, dated 18 May 2020
- Email correspondence between Mr B and the General Medical Council. January 2020
- Electronic Medicines Compendium ('EMC') summary and guidance on Xeplion 150mg pre-filled syringe, 28 February 2020
- Dr S' record on the List of Registered Medical Practitioners February 2020 to current
- Email chain between St Marks Medical Centre and the General Medical Council, August 2022
- Prescriptions written by Dr S for Patients A-P, provided by Dr Peter Peters to the General Medical Council on 25 July 2022, from 8 January 2018 to
  13 July 2018
- Dr Peters' witness statement dated 24 July 2022
- Dr Peters' email to the GMC dated 10 October 2022
- Dr Peter's email to the Tribunal dated 17 October 2022
- Good Practice in Prescribing and Managing Devices' (March 2013) (the 'GPPMDD')

- High level principles for good practice in remote consultations and prescribing, published 8 November 2019 (the 'HLPGPRCP')

The Tribunal's Approach

13. In reaching its decision on 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 Peters does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred.

14. The Tribunal has been told that Dr Peters has had no previous or subsequent findings made against him. The Tribunal therefore reminded itself that the doctor is less likely to have behaved in the way set out in the Allegation. Character evidence of itself does not amount to a defence to any of the particulars or the Allegation. Dr Peters asks that the Tribunal gives considerable weight to his good character when deciding whether the GMC has made out its case.

The Tribunal's Analysis of the Evidence and Findings

15. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

16. The Tribunal noted that following facts are not in dispute:

A doctor (referred to in the bundle as Dr S) in the period January to July 2018 prescribed to a Patients A to R the following drugs (helpfully summarised in the table in Dr E's report of 18 August 2022 at pp540-544):

1. Mimpara in the amount of 90mg tablets (one tablet twice daily) in 4 packs (not prescribed to Patients J to R). Mimpara is a drug used to treat secondary hyperparathyroidism. While Mimpara is a drug that can be prescribed by a GP this should be done in consultation with specialist tertiary services with the relevant expertise and experience.
2. Celsentri in the amount of 150mg tablets (one tablet twice daily) in 4 packs. Celsentri is a drug used to treat HIV. HIV is a complex condition that requires tailored treatment and medication and regular follow ups (see the summary provided in Dr E's expert report of 19 May 2021 in C1 paras 27-36 pp211-214).
3. Xeplion in the amount of 150mg pre-filled syringes (taken as directed) in 4 packs. Xeplion is the 'brand' name for a depot form of paliperidone used for the treatment of schizophrenia, psychosis, or manic symptoms of schizoaffective disorder. The use of Xeplion is complex (see the summary provided in Dr E's expert report of 19 May 2021 C1 paras 37-43 pp214-216). Its complexities are also illustrated by the Xeplion summary and guidance in Exhibit MR4 of Mr B's statement (pp17 and 149-167 C3). Dr E expanded on the risks of Xeplion in his verbal evidence including risks associated with renal impairment

and white cell count. In his verbal evidence Dr E stated that in his practice patients were not supplied with Xeplion since it was normally provided to the patient's GP and that GP then administered the drug by injection. Dr Peters did not challenge Dr E's view that caution was need when combining the use of Xeplion with Celsentri (see Dr E's expert report of 19 May 2021 para 39 C1 p215).

17. Dr S had conditions put on his practice in January 2018, was suspended from the medical register in January 2020 and then erased from the medical register in February 2020. No issues arise from those facts that are relevant to the allegations against Dr Peters. Dr S stopped prescribing in 2018.

18. All the patients were from Egypt. There is no evidence that any of the patients were registered with a UK GP.

19. Dr Peters prescribed the repeat medication to the same patients in the period August 2019 to April 2020 (set out in Schedule 1 of the GMC allegations and again helpfully summarised in the table in Dr E's report of 18.8.22 at pp540-544). Dr Peters maintains that each patient was visiting the UK and sought a renewal of medication that was running out. The process by which Dr Peters prescribed the medication is not clear. It is agreed that he saw none of the patients face to face. It is agreed that he remotely interviewed two patients via telephone or video and recorded some notes of what was revealed which appear in CM1. For the remaining patients Dr Peters says he issued prescriptions based on what Dr S had previously prescribed without providing any evidence that he spoke to any of the patients. There are various handwritten notes on some of the prescriptions written by Dr S which are more likely than not to be notes made by Dr Peters. Dr Peters did not consult or contact Dr S before prescribing to the patients.

20. In deciding whether or not to prescribe the medication Dr Peters did not have any referral letters from any of the patients' doctors or access to their medical records. In the cases Patients R and Q he relied on what they told him and on the previous prescriptions issued by Dr S. For the remaining patients there is no evidence that Dr Peters did anything other than issue repeat prescriptions on request.

21. The only evidence of any discussions between Dr Peters and patients A to R and of any clinical notes in relation to the issue of the prescriptions are handwritten notes relating to Patients Q and R (pp552-553 C1). In relation to Patients A to P no clinical notes or any records have been provided by Dr Peters (despite requests to do so). For Patients A to P there were brief handwritten notes on some of the prescriptions issued by Dr S which Dr S gave evidence were not written by him. We find it more likely than not that Dr Peters was provided with those prescriptions and that Dr Peters wrote the brief notes. It is not disputed that Dr Peters has no specialist training or qualifications in the treatment of secondary hyperparathyroidism or in the prescribing of Mimpara. It is not disputed that Dr Peters has no specialist training or qualifications in the treatment of HIV or in the prescribing of Celsentri. Dr Peters was not a registered GP.

22. Mr D, a pharmacist since 2016 at the Daystar Pharmacy in London confirmed that patients would present him with the private prescriptions issued by Dr Peters, that Mr D would check that the prescription had been issued by a UK registered doctor, that the patient would then pay for the prescription, that Mr D would order the medication from Janssen (since the medications were not common and not kept in stock), ask the patients to return later and the patients would then return and collect the prescribed medication. Most but not all the prescriptions were dealt with by Daystar Pharmacy.

23. Dr Peters' issuing of private prescriptions came to the attention of the GMC as a result of concerns raised in January 2020 by a customer services adviser, Mr A, at the pharmaceutical company Janssen-Cilag (referred to as Janssen). Mr A reported his concerns to his manager Mr B and those concerns were then relayed to the MHRA who referred the concerns to the GMC. It should be noted in fairness to Dr Peters that various matters of concern and suspicions raised by Mr A and Mr B are not the subject of the GMC allegations. It is not necessary for the Tribunal to resolve matters raised by Mr A and Mr B which Dr Peters takes issue with which are not set out in the GMC allegations.

24. It is agreed that the following guidelines were applicable at the time of the Allegation to any UK doctor issuing prescriptions and in particular issuing prescriptions remotely:

1. Good Medical Practice (the 2013 edition) and in particular the following guidance:

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

16: In providing clinical care you must:

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

…

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

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.'

2. Good Practice in prescribing and managing medicines and devices (the 2013 issue) (the 'GPPMDD') which includes the following guidance:

'1: You must recognise and work within the limits of your competence

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.

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.

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.

5: If you are unsure about interactions or other aspects of prescribing and medicines management you should seek advice from experienced colleagues, including pharmacists, prescribing advisers and clinical pharmacologists.

14: You should prescribe medicines only if you have adequate knowledge of the patient's health and you are satisfied that they serve the patient's needs.

21: Together with the patient, you should make an assessment of their condition before deciding to prescribe a medicine. You must have or take an adequate history, including: a any previous adverse reactions to medicines b recent use of other medicines, including non-prescription and herbal medicines, illegal drugs and medicines purchased online, and c other medical conditions.

32: you prescribe for a patient, but are not their general practitioner, you should check the completeness and accuracy of the information accompanying a referral.

33: If a patient has not been referred to you by their general practitioner, you should also:
a. consider whether the information you have is sufficient and reliable enough to enable you to prescribe safely; for example, whether:
i you have access to their medical records or other reliable information about the patient's health and other treatments they are receiving
ii you can verify other important information by examination or testing
b. ask for the patient's consent to contact their general practitioner if you need more information or confirmation of the information you have before prescribing.

If the patient objects, you should explain that you cannot prescribe for them and what their options are.

37: If you prescribe at the recommendation of another doctor, nurse or other healthcare professional, you must satisfy yourself that the prescription is needed, appropriate for the patient and within the limits of your competence.

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

55: You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats to reduce the need for repeat prescribing.

56: As with any prescription, you should agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they: a suffer side effects or adverse reactions, or b stop taking the medicines before the agreed review date (or a set number of repeats have been issued), You must make clear records of these discussions and your reasons for repeat prescribing.

57: You must be satisfied that procedures for prescribing with repeats and for generating repeat prescriptions are secure and that: a the right patient is issued with the correct prescription b the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment c the patient's condition is monitored, taking account of medicine usage and effects d only staff who are competent to do so prepare repeat prescriptions for authorisation e patients who need further examination or assessment are reviewed by an appropriate healthcare professional f any changes to the patient's medicines are critically reviewed and quickly incorporated into their record.

59: When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient. You should keep a record of dispensers who hold original repeat dispensing prescriptions so that you can contact them if necessary.

60: Before you prescribe for a patient via telephone, video-link or online, you must satisfy yourself that you can make an adequate assessment, establish a dialogue and obtain the patient's consent in accordance with the guidance at paragraphs 20–29.

61: [in relation to remote consultations] You may prescribe only when you have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs. You must consider:

a. the limitations of the medium through which you are communicating with the patient
b. the need for physical examination or other assessments
c whether you have access to the patient's medical records.

64: the patient has not been referred to you by their general practitioner, you do not have access to their medical records, and you have not previously provided them with face-to-face care, you must also: a give your name and, if you are prescribing online, your GMC number b explain how the remote consultation will work and what to do if they have any concerns or questions c follow the advice in paragraphs 30–34 on Sharing information with colleagues.'

25. The Tribunal notes that the 'High level Principles for good practice in remote consultations and prescribing' (the 'HLPGPRCP') guidance was published on 8 November 2019, and it is more likely than not that it was fully publicised in response to the Covid 19 outbreak. As a result, to be fair to Dr Peters, the Tribunal has only applied this guidance to the prescriptions issued in April 2020 to Patients Q and R.

3. High level Principles for good practice in remote consultations and prescribing and in particular the 10 principles.

'1. Make patient safety the first priority and raise concerns if the service or system they are working in does not have adequate patient safeguards including appropriate identity and verification checks.

2. Understand how to identify vulnerable patients and take appropriate steps to protect them.

3. Tell patients their name, role and (if online) professional registration details, establish a dialogue and make sure the patient understands how the remote consultation is going to work.

4. Explain that: a. They can only prescribe if it is safe to do so. b. It's not safe if they don't have sufficient information about the patient's health or if remote care is unsuitable to meet their needs. c. It may be unsafe if relevant information is not shared with other healthcare providers involved in their care. d. If they can't prescribe because it's unsafe they will signpost to other appropriate services.

5. Obtain informed consent and follow relevant mental capacity law and codes of practice.

6. Undertake an adequate clinical assessment and access medical records or verify important information by examination or testing where necessary.

7. Give patients information about all the options available to them, including declining treatment, in a way they can understand.

8. Make appropriate arrangements for after care and, unless the patient objects, share all relevant information with colleagues and other health and social care providers involved in their care to support ongoing monitoring and treatment.

9. Keep notes that fully explain and justify the decisions they make.

10. Stay up to date with relevant training, support and guidance for providing healthcare in a remote context.'

26. The HLPGPRCP guidance goes on to state it is important for healthcare professionals and employers to consider the limitations of remote services when deciding the scope of practice and range of medicines prescribed. Some categories of medicines are not suitable to be prescribed remotely unless certain safeguards are in place. The General Pharmaceutical Council has produced guidance which explains that pharmacies based in England, Scotland and Wales may not supply these categories of medicine without having an assurance that these safeguards are in place. The Pharmaceutical Society of Northern Ireland provides standards and guidance on internet pharmacy services for pharmacies based in Northern Ireland.

27. The HLPGPRCP guidance continues by stating that in terms of offering remote services to patients overseas that if UK based healthcare professionals are considering working for service providers based in other countries, it is important to be aware that there may not be established local mechanisms to provide effective systems regulation, and this may impact on patient safety. Before providing remote services to patients overseas the healthcare professional should check if they are required to register with regulatory bodies in the country where they are based, and where the patient is based and where any medicines they prescribe are to be dispensed. They also need to check they have an arrangement in place to provide indemnity or insurance to cover their practice in all relevant countries. When prescribing to a patient overseas, UK based healthcare professionals are expected to consider how they or local healthcare professionals will monitor the patient's condition. The healthcare professional needs to take account of any legal restrictions on prescribing or the supply of particular medicines, and any differences in a product's licensing or accepted clinical use in the destination country. They should follow UK and overseas legal requirements and relevant guidance on import and export for safe delivery, including from the Medicines and Healthcare products Regulatory Agency.

28. The Tribunal noted Dr Peters' response to the Allegation in his email dated 5 October 2022, which states:

'My admission are as follows
1. All the clients have confirmed diagnosis and they have all been established on the medications for over 12 months without any side effect reported
2. All the medications were repeat prescriptions, and the clients have follow up care plans in place in Egypt

3. All the medications were not stimulants or Psychedelic in any shape or form
4. All the medications are not addictive and as such were not sold or bought from the black market
5. I have completely stopped writing any private prescription as a result of this investigation
6. I have held an impeccable reputation over 29 years of practice in the country and 35 years post-graduation in 1987.
7. I am proceeding on voluntary retirement from the 14th of October 2022.
8. [sic]
9. Thank you for taking the time to read through this admissions and God bless.
10. As for the time estimate for the hearing, I feel it should be over by the second day bearing in mind that I would have retired by then and so there is no need for my fitness to practice to be determined anymore.
Yours sincerely
Dr Oludolamu Peter Peters'

29. The Tribunal also noted Dr Peters' email to the GMC dated 10 October 2022, which states:

'*The whole investigation is simple:*
People on holidays in London normally meet [Dr S] for prescriptions but since he was not available, they requested for me to assist.
I did not see any of them face to face and so I cannot have done various tests like Blood pressure and Pulse as requested and also in my submission, I did not write in any mental state examination that I saw them because I did not.
I only repeated previous prescriptions that they have been using for over 18 months without any side effect reported, because they want to avoid use of fake medicine as we all hear in the news recently in The Gambia how 66 children died from adulterated drugs imported from India.'

30. The Tribunal finds the undisputed facts set out above more likely than not to be true. The Tribunal finds it more likely than not that Dr Peters:

1. In prescribing Mimpara and Celsentri was working outside the limits of his competence in breach of para 14 GMP and paras 1 and 57 GPPMDD
2. In prescribing Mimpara, Celsentri and Xeplion he acted without adequate knowledge of the health of each of the patients and without consulting specialist colleagues and without checking that drugs prescribed were compatible with each other and with any other treatments the patient was receiving in breach of para 16 GMP and paras 1, 14 and 61 GPPMDD
3. In relation to Patients A to P failed to make any records of the reasons for the repeat descriptions in breach of paras 19 and 21 GMP and in the cases of Patients Q and R failed to make adequate clinical records in breach of para 21 GMP
4. In relation to all of the patients failed to take an adequate history in breach of para 21 GPPMDD

5. Not being the GP for any of the patients failed to check the completeness and accuracy of information in breach of paras 32 and 33 GPPMDD
6. In repeating the prescriptions of Dr S failed to satisfy himself that each of the prescriptions was needed, appropriate and within the limits of his competence in breach of para 37 GPPMDD
7. Failed to ensure that suitable arrangements were in place for monitoring, follow up and reviews, taking into account each of the patient's needs and any risks arising from the medicines in breach of paras 55 and 56 GPPMDD
8. In repeating the same levels of medication prescribed by Dr S failed to consider the correct dose for each patient in breach of paras 57 and 59 GPPMDD
9. In relation to Patients R and Q failed to undertake an adequate clinical assessment or verify important information in breach of Principle 6 HLPGPRCP
10. In relation to Patients R and Q failed to keep notes that fully explained and justified the decisions he made in breach of Principle 9 HLPGPRCP
11. In relation to Patients R and Q failed to consider the limitations of remote consultations and the suitability of prescribing remotely each of the medicines contrary to the guidance following the 10 principles in HLPGPRCP

31. Turning to the individual allegations the Tribunal accepts the comments and conclusions in Dr E's various reports. Dr Peters provided no effective challenge to what Dr E stated in his reports. Dr Peters did not take up the opportunity to attend the hearing and challenge Dr E. The Tribunal found Dr E a clear, convincing, credible and thorough witness. The Tribunal finds that the factual basis for the opinions expressed by Dr E is made out. The Tribunal accepts and agrees with his expert evidence as to the failings of Dr Peters that go to each of the GMC allegations. We were greatly assisted by Mr Jackson KC (with the assistance of his instructing GMC solicitor) referencing the relevant sections of Dr E's reports so far as they related to each allegation.

32. The Tribunal now turns to each allegation and its findings.

Paragraph 1a

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that before prescribing, you failed to assess the patient(s) at all.

33. The Tribunal noted Dr E's report dated 4 April 2022 in relation to Dr Peter's assessment of Patients A to P. It noted that for every patient Dr E referred to the following *GMC prescribing guideline which states:*

> *- 'You should only prescribe medicines if you have adequate knowledge of the patient's health and you are satisfied that the medicines serve the patient's needs. …you have sufficient information to prescribe safely, for example if you have access to the patient's medical records and can verify relevant information….'*,

34. Dr E reported Patients A to P as follows:

Patient A

> *'46. In Patient A's case, Dr Peters has provided no evidence that he had access to any background information regarding Patient A's medical and/or psychiatric history, current medication details, blood, or imaging results. Indeed, there is no evidence that Dr Peters carried out any assessment whatsoever, in which case he would have had no opportunity to assess Patient A's mental or physical presentation;*

35. Dr E then repeated the same wording and findings in relation to Patient B at paragraph 54, Patient C at paragraph 62, Patient D at paragraph 70, Patient E at paragraph 78, Patient F at paragraph 86, Patient G at paragraph 94, Patient H at paragraph 102, Patient I at paragraph 110, Patient J at paragraph 118, Patient K at paragraph 125, Patient M at paragraph 139, Patient N at 146, Patient O at paragraph 153 and Patient P at paragraph 160. Since Dr E has used identical wording there is no need to set out the same wording for each of Patients B to P.

> *'104. With regards the prescribing of Xeplion, Dr Peters provides no evidence that he assessed Patient H's mental state or had adequate knowledge of Patient H's medication history to allow him to screen for possible drug interactions. In particular, there is no evidence that Dr Peters had the reassurance of any ECG result (an ECG is advised prior to commencement of Xeplion), nor any physical observations – blood pressure, pulse rate, heart sounds, height, weight (BMI [body mass index]), which might have been useful in assessing cardiac risk [TDB comment: Dr Peters should have arranged/checked these tests before prescribing, although I am unsure how feasible it would have been to arrange these tests remotely, particularly as there is no record of any discussion with any of Patient treating clinician(s)].'*

36. Dr E then repeated the same wording and findings in relation to Patient I at para 112, Patient J at para 120., Patient L at para 134, Patient M at para 141, Patient N at para 148, Patient O at para 155 and Patient P at para 162. Since Dr E has used identical wording there is no need to set out the same wording for each of these patients.

> *'123. In all required aspects of an adequate assessment, as discussed above in paragraphs 117 to 122, Dr Peters' care of Patient J's in this regard was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist'.*

Patient K

> *'124. GMC guidance 'Good practice in prescribing and managing medicines and devices'31 states that doctors must primarily decide whether their prescribing is safe for the patient; safe prescribing necessarily entails collating the patient's medical and/or psychiatric history, accessing current medication details and results of any relevant blood tests and imaging. When assessing face to face, physical observations can be made, and relevant organic screening is feasible. When assessing remotely, clinicians are entirely dependent upon verified information passed on by the patient's usual treating clinician(s).'*

37. The Tribunal noted that in Dr Peters' email to the GMC dated 10 October 2022 he stated that he did not see any of the patients face to face. The Tribunal relied on the unchallenged evidence from Dr E's report dated 4 April 2022 and was satisfied that *before prescribing,* Dr Peters failed to assess the patient(s) at all. Accordingly, the Tribunal found Paragraph 1a proved.

Paragraph 1b(i)

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that b. in respect of Patients A-I, you prescribed Mimpara, and you did so outside the limits of your competence without conferring with the relevant specialists.

38. The Tribunal noted paragraph 39 of Dr E's report dated 4 April 2022 and paragraph 63 of his report dated 14 October 2022, which state:

> *'39. Mimpara is a drug which requires both expertise in its use and careful monitoring. The BNF cites manufacturer's advice to use caution, particularly when treating patients with conditions that may worsen with a decrease in serum-calcium concentrations, including predisposition to QT-interval prolongation, history of seizures, and history of impaired cardiac function; serum-calcium concentration should be closely monitored.*
>
> *63. It is now clear that although Dr Peters did not initiate Mimpara in Patients A, B, and C, neither did he make any contact at all with any previous treating clinician, and Dr S has confirmed that he had no contact with Dr Peters and was not treating and/or monitoring any of the patients for whom he wrote prescriptions. Therefore, Dr S was not Patient A-R's 'usual doctor', he had not initiated any treatment, so Dr Peters cannot argue that he was prescribing under the guidance of Dr S (who was a GP). So clearly Dr Peters was prescribing out of his area of expertise in all cases of Mimpara (and Celsentri).'*

39. The Tribunal noted that Dr Peters is a psychiatrist. It also noted that Mimpara is a drug used to treat secondary hyperparathyroidism which requires both expertise in its use and careful monitoring. The Tribunal has no evidence that Dr Peters conferred with a relevant specialist. The Tribunal relied upon the unchallenged evidence of Dr E and was satisfied that Dr Peters prescribed Mimpara and did so outside the limits of his competence without conferring with the relevant specialists. Accordingly, the Tribunal found paragraph 1b(i) proved.

Paragraph 1b(ii)

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that in respect of Patients A-I, you prescribed Mimpara, and you failed to, before prescribing, establish the relevant patient's 1. blood pressure, 2. pulse rate, 3. heart sounds, 4. most recent ECG test result and 5. blood test result for (i) serum calcium levels and (ii) parathyroid hormone levels

40. The Tribunal noted paragraphs 48 and 50 of Dr E's report, which state:

'48. With regards the prescribing of Xeplion, Dr Peters provides no evidence that he assessed Patient A's mental state or had adequate knowledge of Patient A's medication history to allow him to screen for possible drug interactions. In particular, there is no evidence that Dr Peters had the reassurance of any ECG result (an ECG is advised prior to commencement of Xeplion), nor any physical observations – blood pressure, pulse rate, heart sounds, height, weight (BMI [body mass index]), which might have been useful in assessing cardiac risk [TDB comment: Dr Peters should have arranged/checked these tests before prescribing, although I am unsure how feasible it would have been to arrange these tests remotely, particularly as there is no record of any discussion with any of Patient A's treating clinician(s)].

50. Regarding Dr Peter's prescribing Mimpara to Patient A again, the complete absence of any documented records of physical observations (ECG, blood pressure, pulse rate, heart sounds), or medical history (in particular, screening for cardiac disease), was significantly inadequate, as side effects of Mimpara include heart failure, ventricular arrythmia, and QT interval prolongation. Crucially, Mimpara should not have been commenced or continued in the absence of feasible monitoring of serum calcium and parathyroid hormone levels.'

41. The Tribunal noted Dr Peters' statements:

'…. all I was doing is providing repeat prescription for persons on holiday or passing through the UK who required medications at this time to keep them well and who if not given these medications may suffer deterioration in their physical health or suffer mental breakdown. He (Dr E) also did not factor in that I was only writing a repeat prescription; copying prescriptions that were written by a UK based consultant physician, (Dr S)….

…I did not see any of them face to face and so I cannot have done various tests like Blood pressure and Pulse as requested and also in my submission, I did not write in any mental state examination that I saw them because I did not'

…I could not examine these patients to the extent suggested but I have taken steps to ensure that the clients were well settled and established on these medications. They already have established diagnoses and treatment plans which has kept the patients well over the previous years'

42. The Tribunal took account of Dr E's oral evidence who stated that all these tests and investigations should be done in order to fulfil Dr Peters' obligation to the patient under 'Good Medical Practice 2013' (2013), 'Good Practice in Prescribing and Managing Devices' (March 2013).

43. The Tribunal relied on the unchallenged evidence from Dr E's reports that before prescribing Mimpara Dr Peters had a duty to establish from Patients A to P relevant information which included the patient's blood pressure, pulse rate, heart sound, most recent ECG test result and blood test results for serum calcium levels and parathyroid hormone levels and that Dr

Peters failed to ask for or obtain any of this information. We therefore found each aspect of allegation 1(b)(ii) proved.

Paragraph 1b(iii)
Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in respect of Patients A-I, you prescribed Mimpara, and you failed to arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1bii1-5 above

44. The Tribunal noted paragraph 55 of Dr E's report dated 14 October 2022, which states:

> *'55. Both processes were listed to reflect how Dr Peters should have ensured the safety of the prescribing process. Dr Peters did* ***neither*** *when he should have done both. All three medications prescribed required monitoring – as outlined in some detail within my report dated 4 April 2022. In particular, please note paragraph 41 - 'Side effects with unknown frequency include heart failure, QT interval prolongation and ventricular arrhythmia'. It is not possible to predict if, or when, these side effects might occur, therefore ongoing monitoring is essential, to establish fitness for medication at time of prescribing and to arrange for future tests to screen for any deterioration of cardiovascular status.'*

45. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty if appropriately prescribing Mimpara to arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1(b)(ii) 1-5 above. The Tribunal is satisfied that Dr Peters failed to comply with this duty and finds paragraph 1(b)(iii) proved.

Celsentri

Paragraph 1c
1c(i) Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Celsentri and failed to obtain, before prescribing, a recent white cell count/viral load result for the patient.

1c(ii) Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that c. you prescribed Celsentri and failed to arrange for the prompt follow up monitoring of the patient's white cell count/viral load.

1c(iii) Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that c. you prescribed Celsentri and failed to have contact and guidance from specialist HIV services when prescribing Celsentri.

1c(iv) Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that c. you prescribed Celsentri and failed to check for drug interactions.

1c(v) Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that c. you prescribed Celsentri and failed to liaise with HIV services to ensure the patient had follow up and monitoring.

46. In relation to Celsentri the Tribunal noted paragraphs 29 to 36 of Dr E's report dated 19 May 2022, which state:

> *'29. It is recommended (due to the large number of medicine interactions) that whenever prescribing for this condition, drug interactions should be checked via the British National Formulary [BNF], the online HIV interactions database or with an HIV specialist1. Guidelines for HIV treatment and monitoring are also provided on the British HIV Association website* (www.bhiva.org).
>
> *30. Celsentri (maraviroc) is an antagonist of the CCR5 chemokine receptor and is indicated for use in the treatment of HIV infection – 'particularly CCR5-tropic HIV infection' – usually prescribed in combination with other antiretroviral drugs in patients previously treated with antiretrovirals which have become ineffective.*
>
> *According to Healthline.com, in an overview of HIV treatment2, CCR5 is an 'entry inhibitor' and stops HIV from entering immune system cells; these medications are usually reserved for those patients who are running out of options, due to many drug resistant mutations of HIV.*
>
> *31. Healthline.com also states CCR5 medications are rarely used in the USA as other medications are more effective; it is advised CCR5 medications should only be used for patients who have tested positive for CCR5-tropic HIV infections.*
>
> *32. Common side effects (as cited in the BNF3) include abdominal pain, anaemia, appetite decreased, asthenia, depression, diarrhoea, flatulence, headache, insomnia, nausea, and rash. Less common (but more serious) side effects include renal failure, angina, neoplasms, pancytopenia, severe cutaneous reactions, hepatotoxicity, and osteonecrosis.*
>
> *33. Secondary services - usually specialist HIV services – normally initiate treatment - the initiation of HIV medication is complex. Any choice of antiretroviral therapy should be made on an individualised basis; thus, viral load, renal, liver and heart condition should be reviewed prior to prescribing. Additionally, prescribing should take into account drug resistance testing. Any concomitant depression, anxiety and other mental health disorders should also be considered.*
>
> *34. Patient concerns which may influence choice of drug treatment are - likely side-effects, shift-work patterns, and dietary requirements. NICE recommend that the role of Primary Care should include provision of advice on screening and immunisation (for instance, HIV positive individuals should not receive live vaccines), sexual and reproductive health, management of mental health issues,*

management of HIV related problems (such as antibiotic treatment for opportunistic infections) and generally promote positive approaches to health maintenance by ensuring the patient engages with specialist services wherever possible.

35. Monitoring HIV infection using CD4 counts and viral load usually requires the involvement of specialist services. Clinicians must emphasise the risks associated with non-adherence to medication, which can lead to irreversible treatment resistance; this can occur within a week with some ART [antiretroviral therapy] medications.

36. Finally, patients should be aware of possible interactions with dietary substances, herbal remedies and recreational drugs and should seek advice on sexual health precautions. On the NICE website current advice is that management should be within secondary care and they warn - 'ART can also have serious or life-threatening interactions with many drugs commonly prescribed in primary care - before prescribing, drug interactions should be checked in the British National Formulary, the online database of HIV drug interactions, or with an HIV specialist. 5' However, it is routine for primary care services to reach agreement on issuing repeat prescriptions at the request of secondary care services. Secondary care psychiatric services would not normally prescribe medication for the treatment of HIV, other than for inpatients, and in such circumstances, clinicians would be guided by specialist HIV services when prescribing (taking account all factors cited in paragraphs 33 - 34).'

47. In relation to paragraph 1c(ii) the Tribunal noted paragraphs 38 and 55 (as above) of Dr E's report, which state:

'38. There are a number of conditions for which it must be used with caution, including cardiovascular disease, seizures, depression, diabetes, jaundice, Parkinson's, severe respiratory disease. HIV is not listed within the section on 'cautions', however given that diminished white cell count levels is a potential side effect of paliperidone (Xeplion), in my opinion, this would raise my level of caution for use in patients positive for HIV infection; in such cases I would ensure the patient was having regular CD4 white counts and viral load testing.'

48. In relation to paragraph 1c(iii) the Tribunal noted paragraphs 33 to 36 (as above), 91, 137, 138 and 139 of Dr E's report, which state:

'91. In my opinion, Dr Peters' addendum, whilst providing some explanation, does not justify his decision to prescribe taking GMC guidance and patient safeguards, into account. Dr Peters apparently failed to consider the risk to patients of these medications were the medication to be diverted - particularly the HIV medication (which is only available through specialist HIV services in the UK). Regarding GMC Principle Nine (please see paragraph 89 above) for remote prescribing, in my opinion Dr Peters' assessment was seriously below the expected standard of a reasonably competent Associate Specialist Psychiatrist.

137. Dr Peters should not have prescribed to Patient R without the adequate GMC safeguards in place as cited above and he should have informed him of this. In particular, Dr Peters should have made contact with medical professionals and authorities in Egypt to gain documentation ensuring it was appropriate for him to prescribe. Dr Peters should have liaised with HIV services, as this was an area outside Dr Peters' expertise.

138. Indeed, without the support or advice from HIV services, Dr Peters' prescribing both non-remotely or remotely must be considered seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist due to the potentially fatal consequences for patients or the public taking medication of this nature without supervision.

139. Dr Peters should not have prescribed to Patient Q without the adequate GMC safeguards in place as above and he should have informed Patient Q of this. In particular, Dr Peters should have made contact with medical professionals and authorities in Egypt to gain documentation ensuring it was appropriate for him to prescribe. Dr Peters should have liaised with HIV services, as this was an area in which Dr Peters had no particular expertise.'

49. In relation to paragraph 1c(v) the Tribunal noted paragraphs 298, 306, 307, 214 and 315 of Dr E's report, which state:

'298. However, as stated above, in paragraph 27 above, Celsentri (an ART medication) relies on patient compliance to avoid possible life threatening consequences during HIV treatment. Any change or discontinuation of ART medications can result in a life-threatening patient outcome, due to the risk of the patient developing treatment resistance. All ART medications require specialist monitoring of a patient's condition and any lack of monitoring (as carried out by specialist HIV services) can result in a life-threatening patient outcome.

306. However, as stated above, in paragraph 27 above, Celsentri (an ART medication) relies on patient compliance to avoid possible life-threatening consequences during HIV treatment. Any change or discontinuation of ART medications can result in a life-threatening patient outcome, due to the risk of the patient developing treatment resistance. All ART medications require specialist monitoring of a patient's condition and any lack of monitoring (as carried out by specialist HIV services) can result in a life-threatening patient outcome.

307. I would be cautious regarding the use of Xeplion in patients diagnosed with HIV, due to the possible side effect of Xeplion lowering white cell counts; this risk would be beyond acceptable in a scenario where adequate monitoring could not be confirmed. As stated above, an ECG is recommended, prior to commencement of therapy with Xeplion.

314. However, as stated above, in paragraph 27 above, Celsentri (an ART medication) relies on patient compliance to avoid possible life-threatening consequences during HIV

treatment. Any change or discontinuation of ART medications can result in a life-threatening patient outcome, due to the risk of the patient developing treatment resistance. All ART medications require specialist monitoring of a patient's condition and any lack of monitoring (as carried out by specialist HIV services) can result in a life-threatening patient outcome.

315. I would be cautious regarding the use of Xeplion in patients diagnosed with HIV, due to the possible side effect of Xeplion lowering white cell counts; this risk would be beyond acceptable in a scenario where adequate monitoring could not be confirmed. As stated above, an ECG is recommended, prior to commencement of therapy with Xeplion.'

50. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty, before prescribing Celsentri to obtain from each patient a recent white cell count/viral load result, after prescribing Celsentri to arrange for each patient a prompt follow up monitoring of each patient's white cell count/viral load, before, during and after prescribing Celsentri have contact and guidance from specialist HIV services, as part of the process of prescribing to check for drug interactions and after prescribing to liaise with HIV services to ensure each patient had follow up and monitoring. The Tribunal was satisfied that Dr Peters failed to do of these actions and that paragraph 1c is proved in its entirety.

<u>Xeplion</u>

Paragraphs 1d(i)1 to 1d(i)6

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Xeplion and failed to establish, before prescribing, the relevant patient's 1. blood pressure, 2. pulse rate, 3. heart sounds, 4. height, 5. weight and 6. ECG

51. The Tribunal noted paragraphs 37 and 48 (as above) of Dr E's report, which state:
'37. Xeplion (the 'brand' name for a depot form of paliperidone) is indicated for the treatment of schizophrenia, psychosis, or manic symptoms of schizoaffective disorder. Paliperidone is the major metabolite of risperidone; it has similar receptor antagonism of dopamine and 5-HT2 receptors, which appears to be its main mechanism of effectiveness in treating or ameliorating symptoms of psychotic illness. Maintenance dose varies between 25mg and 150mg monthly.'

52. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty before prescribing Xeplion to obtain from each patient that patient's blood pressure, pulse rate, heart sounds, height, weight and ECG. The Tribunal is satisfied that Dr Peters failed to obtain or establish any of this information and finds paragraphs 1d(i)1 to 1d(i)6 proved.

Paragraph1d(ii)

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Xeplion and failed to arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1di.

53. The Tribunal noted paragraph 55 (as above) of Dr E's report.

54. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty after prescribing Xeplion to arrange for each patient a prompt follow up monitoring of one or more of the clinical indicators set out in paragraph 1(d)(i). The Tribunal is satisfied that Dr Peters failed to make any of these arrangements and finds paragraph 1d(ii) proved.

Paragraph 1d(iii)
Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Xeplion and failed to ascertain the mental state of the patient before prescribing.

55. The Tribunal noted paragraphs 48 (as above) 78, 79, 82, 93, 100, 103 and 117 of Dr E's report, which state:

> *'78. A standard first psychiatric assessment should include a full psychiatric history, mental state examination, physical assessment if indicated (for example if Patient was developing extrapyramidal symptoms from the medication and needed assessment of their coordination, tremor, and gait. Or if their HIV was out of control and they were developing AIDS symptoms such as lymphadenopathy and Kaposi sarcoma), risk assessment, formulation, and diagnosis, with treatment recommendations. Dr Peters' assessment was brief, seemingly focussing on providing a repeat prescription for Patient without re-evaluation of his medical or psychiatric condition. Dr Peters did not document any formal mental state examination. There are GMC guidelines11 for remote assessments and for prescribing as noted above.*
>
> *79. For adequate assessment and examination by remote means, such as telephone, online, or videoconferencing, doctors should fulfil the requirements as per GMC advice12; previous advice was disparate and in an attempt to clarify 'principles' have been elucidated; this is not new guidance. 'The principles are underpinned by existing standards and guidance from professional and system regulators. Healthcare professionals should continue to follow guidance from regulatory bodies and take clinical guidance into account in their decision making. These principles have been co-authored and agreed by a range of healthcare regulators and organisations.'*
>
> *82. Dr Peters' assessment contained insufficient corroborated information regarding Patient 's treatment and follow up in Egypt, which was only verifiable by direct communication with the GP, and mental health and HIV specialists. He did not include a standard mental state examination or risk assessment.*
>
> *93. a. Dr Peters' notes are highly summarised, but there is some indication he enquired at least somewhat about Patient R's mental state, however no formal assessment mental state examination was documented.*
>
> *100. The format and content of Dr Peters' assessment and examination of*

Patient is very similar to that of Patient As explained above a standard 'first assessment' of any patient should include a full psychiatric history, a mental state examination, physical assessment if indicated, risk assessment, formulation and diagnosis, and treatment recommendations and follow up. Dr Peters' assessment was brief and focused, apparently on providing a repeat prescription for both patients with no significant re-evaluation of Patient's psychiatric condition and no formal mental state examination.

103. Dr Peters provided no corroborating source of information regarding Patient Q's care in Egypt (which could only have been verified by the GP, or mental health and HIV specialists). Dr Peters ought to have explained to Patient Q that it was unsafe to prescribe without confirmation of same and further detail of his ongoing treatment. There was no formal mental state examination or risk assessment which should have been part of the clinical assessment. As no medical records were available and in the absence of a referral letter or verification of Patient Q's case details, Dr Peters' prescribing was not safe practice.

117. a. Dr Peters' notes are highly summarised, but there is some indication he enquired at least somewhat about Patient Q's mental state; however, no formal assessment mental state examination as such was documented.'

56. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty before prescribing Xeplion to ascertain the mental state of each patient. The Tribunal is satisfied that Dr Peters failed to make any such check and finds Paragraph 1d(iii) proved.

Paragraph 1d(iv)
Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Xeplion and failed to check for drug interactions.

57. The Tribunal noted paragraph 48 of Dr E's report (as above).

58. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty before prescribing Xeplion to check for drug interactions. The Tribunal is satisfied that Dr Peters failed to make any such check and finds paragraph 1d(iv) proved.

Paragraph 1d(v)
Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Xeplion and failed to review the patient's recent metabolic status.

59. The Tribunal noted paragraph 49 of Dr E's report, which states:

'49. Due to the lack of medical history, there is no evidence whether Patient A suffered from any condition with which Xeplion must be used with caution (see paragraph 30 above). There is no evidence of Patient A's metabolic status having been reviewed (blood

glucose, HbA1c, lipids, full blood count, renal function, liver function, and prolactin levels).'

60. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty before prescribing Xeplion to review each patient's recent metabolic status. The Tribunal is satisfied that Dr Peters failed to conduct any such review and finds paragraph 1d(v) proved.

Paragraph 1d(vi)

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Xeplion and failed to record any handover to the patient's usual treating clinician(s).

61. The Tribunal noted paragraph 48 of Dr E's report (as above).

62. The Tribunal relied on the unchallenged evidence from Dr E's reports that Dr Peters had a duty after prescribing Xeplion to record any handover to the patient's usual treating clinician(s). The Tribunal is satisfied that Dr Peters failed to record any such handover and finds paragraph 1d(vi) proved.

Paragraph 1e

Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that you prescribed Celsentri and Xeplion together, without arranging for the monitoring of any side effects.

63. The Tribunal noted paragraphs 32, 34, 38(as above) 39, 184, 188, 215 298 and 299 of Dr E's report, which state:

'32. Common side effects (as cited in the BNF3) include abdominal pain, anaemia, appetite decreased, asthenia, depression, diarrhoea, flatulence, headache, insomnia, nausea, and rash. Less common (but more serious) side effects include renal failure, angina, neoplasms, pancytopenia, severe cutaneous reactions, hepatotoxicity, and osteonecrosis.

34. Patient concerns which may influence choice of drug treatment are - likely side-effects, shift-work patterns, and dietary requirements. NICE recommend that the role of Primary Care should include provision of advice on screening and immunisation (for instance, HIV positive individuals should not receive live vaccines), sexual and reproductive health, management of mental health issues, management of HIV related problems (such as antibiotic treatment for opportunistic infections) and generally promote positive approaches to health maintenance by ensuring the patient engages with specialist services wherever possible.

39. I note HIV patients are particularly susceptible to extrapyramidal symptoms (these are neurological symptoms such as movement disorders, see paragraph 42 below, associated with mental disorders and use of antipsychotic medication). Quetiapine, risperidone, and

aripiprazole are common first-line choices for treatment of psychosis in patients with HIV6. Common side effects as listed in the BNF are similar to those for other antipsychotic medication and include agitation, arrhythmia, constipation, dizziness, drowsiness, dry mouth, erectile dysfunction, galactorrhoea, gynaecomastia, hyperprolactinaemia, hypotension, insomnia, leukopenia (lowering of white cell count), movement disorders, neutropenia, Parkinson's, QT interval prolongation, rash, seizure, tremor, urinary retention, weight increase and vomiting. Less common and rare side effects of significant importance include agranulocytosis, angioedema, pancreatitis, embolism, neuroleptic malignant syndrome and sudden death. A comprehensive list of side effects is available on the BNF available at www.bnf.nice.org.uk.

184. The GMC Good practice18 makes recommendations for prescribing to a capacitous patient: 'You should reach agreement with the patient on the treatment proposed, explaining: the likely benefits, risks and burdens, including serious and common side effects, what to do in the event of a side effect or recurrence of the condition, how and when to take the medicine and how to adjust the dose if necessary, or how to use a medical device, the likely duration of treatment, arrangements for monitoring, follow up and review, including further consultation, blood tests or other investigations, processes for adjusting the type or dose of medicine, and for issuing repeat prescriptions.'

188. GMC advises 19 - as with any prescription you should agree which medications are appropriate how the condition should be managed and date for review. Also, what they should do if they get side effects, and they stop the medication before the review 'you must make clear records of these discussions and your reasons for repeat prescribing'.

298. However, as stated above, in paragraph 27 above, Celsentri (an ART medication) relies on patient compliance to avoid possible life-threatening consequences during HIV treatment. Any change or discontinuation of ART medications can result in a life-threatening patient outcome, due to the risk of the patient developing treatment resistance. All ART medications require specialist monitoring of a patient's condition and any lack of monitoring (as carried out by specialist HIV services) can result in a life-threatening patient outcome.

299. I would be cautious regarding the use of Xeplion in patients diagnosed with HIV, due to the possible side effect of Xeplion lowering white cell counts; this risk would be beyond acceptable in a scenario where adequate monitoring could not be confirmed. As stated above, an ECG is recommended, prior to commencement of therapy with Xeplion.'

64. The Tribunal relied on the unchallenged evidence from Dr E's reports that when prescribing Celsentri and Xeplion together Dr Peters had a duty to arrange for the monitoring of any side effects. The Tribunal is satisfied that there a was a risk to each patient of side effects as a result of prescribing Celsentri and Xeplion together. The Tribunal is satisfied that Dr Peters failed to make any arrangements for the monitoring of any side effects and finds paragraph 1e proved.

Paragraph 2a
Your record keeping was inadequate in that (in the alternative to paragraph 1bii-1biii) when prescribing Mimpara to Patients A-I, as described in Schedule 1, you failed to record having undertaken the actions referred to in paragraph 1bii-1biii.

65. The Tribunal having found paragraphs 1b(ii and 1b(iii) proved did not consider the alternative in paragraph 2a.

Paragraph 2b(i)
Your record keeping was inadequate in that when prescribing to Patients A-P as described in Schedule 1, you failed to record (in the alternative to paragraph 1a) an adequate assessment of the patient.

66. The Tribunal having found paragraphs 1a proved did not consider the alternative in paragraph 2b(i.)

Paragraph 2b(ii)
Your record keeping was inadequate in that when prescribing to Patients A-P as described in Schedule 1, you failed to record (in the alternative to paragraph 1c-e) having adequately undertaken the actions referred to in paragraph 1c-e.

67. The Tribunal having found paragraphs 1c-e proved did not consider the alternative in paragraph 2b(ii).

Paragraph 2c
Your record keeping was inadequate in that in respect of Patient I, you failed to document your reasons for initiating treatment with Mimpara

68. The Tribunal noted paragraph 64 of Dr E's report, which states:

> *'64. Because Dr Peters has now produced prescriptions which included previous prescriptions for Mimpara for Patient A, B, and C written by Dr S. Hence only Patient I's treatment may have been initiated by Dr Peters.'*

69. The Tribunal was satisfied that Dr Peters had a duty to document his reasons for initiating treatment with Mimpara as a result of para 19 GMP and para 1 GPPMMD. It also accepted the unchallenged evidence of Dr E that Dr Peters had a duty to provide clear written reasons for initiating treatment with Mimpara. The Tribunal is satisfied that Dr Peters failed to document any reasons and finds paragraph 2c proved.

Patient Q

Paragraph 3a(ii) and 3a(ii)

On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to obtain consent to 1.access Patient Q's medical records and to 2. treat Patient Q

70. The Tribunal noted paragraph 125 of Dr E's report, which states:

> *'125. Principle One was not evidenced in the documentation by Dr Peters, therefore it is unlikely to have been applied to the assessment of Patient R. No verification and identity checks of Patient R were recorded, for example, checking of passport. Was the remote system (Skype, Zoom, etc.,) adequate to allow dialogue without interference and was there adequate interpretation if needed? Safety checks before prescribing include sufficient information about Patient's health being available; there was no evidence of same and this was seriously below the level expected of a competent Associate Specialist Psychiatrist. Patient R had a history of homelessness and was particularly vulnerable in this respect'.*

71. The Tribunal accepted the unchallenged evidence of Dr E that Dr Peters had a duty before prescribing Celsentri and Xeplion to verify Patient Q's identity by asking Patient Q to produce to Dr Peters remotely a document such as a passport, identity document or photo driving licence to confirm Patient Q was who he/she said they were. The Tribunal notes the duty in paragraph 57 GPPMMD that the right person is issued with the correct prescription. The Tribunal notes the duty for appropriate identity and verification checks in Principle One HLPGPRCP. The Tribunal is satisfied that it was not acceptable for Dr Peters to simply rely on what Patient Q told him. The Tribunal is satisfied that Dr Peters had no prior knowledge of Patient Q, no referral letter and no access to Patient Q's health records. The Tribunal noted that Celsentri and Xeplion were unusual and expensive medicines for complex conditions which in the Tribunal's judgement only heightened the duty on Dr Peters to verify Patient Q's identity. Dr Peters provided no proof of any checks, and the Tribunal finds it more likely than not that no checks were done. The Tribunal finds paragraph 3a(i) proved.

72. The Tribunal accepted the unchallenged evidence of Dr E that before prescribing Celsentri and Xeplion that Dr Peters had a duty to obtain the consent of Patient Q for access to his/her medical records. The Tribunal is satisfied that Dr Peters had a duty to access Patient Q's medical records as a result of para 33 GPPMMD. Dr Peters has provided no evidence that he obtained any kind of consent from Patient Q. The Tribunal is satisfied that it is more likely than not that Dr Peters failed to obtain the consent of Patient Q to access his/her medical records indeed that Dr Peters failed to make any attempt to access Patient Q's medical records.

73. The Tribunal accepts the unchallenged evidence of Dr E that Dr Peters had a duty to obtain Patient Q's consent to treat Patient Q and in particular prescribe Celsentri and Xeplion. The Tribunal notes the duty in para 21 GPPMMD for Dr Peters and Patient Q to make a joint assessment, the duty in para 56 GPPMMD to agree with the patient on what medicines are appropriate and the duty in para 60 GPPMMD to obtain consent. Dr Peters has provided no evidence that he obtained any kind of consent from Patient Q. The Tribunal is satisfied that it is more likely than not that Dr Peters failed to obtain the consent of Patient Q to treat Patient Q.

74. The Tribunal finds paragraphs 3(a)(i) and (ii) proved.

Paragraphs 3a(iii)1 to 3a(iii)7

On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to take an adequate history, in that you did not make an appropriate enquiry about Patient Q's 1. presenting complaint, 2. psychiatric history, 3. medical history, 4. background history, 5. timing of depot medication to determine whether Patient Q had relapsed with medication in their system, 6 previous blood transfusion, 7 possible use of (i) alternative remedies (ii) alcohol; (iii) illegal substances; and (iv) other medications contained online.

75. The Tribunal noted paragraph 54, 164 and 195 of Dr E's report, which state:

> *'54. Presenting complaint assessment should include history of presenting complaint, psychiatric history past medical history (including relevant family history , personal and social history, a drug and alcohol history, a forensic history and a personality history, In the case of depot mechanism, timing of depot timing of medication required was required to determine whether Patient R relapsed with medication in their system, Patient R's current circumstances, recent compliance, evolving medical conditions , previous allergies, use of alternative remedies, possible use of alcohol and illegal substances, any other medications obtained online, are all relevant to a comprehensive assessment.*
>
> *164. There is no record of Patient R consenting to Dr Peters having access to Patient R's GP or his medical records, nor is there a record of Dr Peters seeking consent for same.*
>
> *195. In this aspect, Dr Peters' care and treatment of Patient R therefore did not meet GMC guidance for remote prescribing. There was no documentation of assessment of capacity of Patient R nor is it recorded that Patient R consented to treatment.'*

76. The Tribunal is satisfied on the unchallenged evidence of Dr E that before prescribing Celsentri and Xeplion to Patient Q there was a duty on Dr Peters to take an adequate history by asking Patient Q about his/her presenting complaint, psychiatric history, medical history, background history, timing of depot medication (to determine whether Patient Q had relapsed with medication in their system), previous blood transfusion and possible use of (i) alternative remedies (ii) alcohol; (iii) illegal substances; and (iv) other medications contained online. The Tribunal notes the duty in para 16 GMC to check that the care or treatment provided is compatible with any other treatment the patient is receiving and the duty in paragraph 1 GPPMMD only to prescribe when a doctor has adequate knowledge of the patient's health and are satisfied that any drugs prescribed meet the patient's needs. The Tribunal notes the duty in paragraph 14 GPPMMD that a doctor should only prescribe medicines if the doctor has adequate knowledge of the patient's health and that the prescribed medicines serve the patient's needs. The Tribunal notes the duty in paragraph 33 GPPMMD where a patient has not been referred by their GP to consider whether the information available is sufficient and reliable enough to enable safe prescribing. The Tribunal notes the duty in para 61 for remote consultations for the doctor

to only prescribe if satisfied that the doctor has adequate knowledge of the patient's health. The Tribunal notes the handwritten notes provided by Dr Peters in relation to the consultation with Patient Q. The Tribunal is satisfied that those notes are materially inadequate, do not amount to an adequate history and do not adequately cover or cover at all the material information set out above. The Tribunal finds Paragraphs 3a(iii)1 to 3a(iii)7 proved.

Paragraph 3a(iv)

On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to conduct an adequate risk assessment of Patient Q.

77. The Tribunal noted paragraph 119 of Dr E's report, which states:

> *'119. c. Risk assessment is required as part of any 'adequate clinical assessment', and this is particularly important when prescribing for the first time. Often this information will come with the patient, i.e., suicidality, risk of self-harm, violent thoughts, compliance, substance misuse, absconding risk, risk of arson, sexual, radicalisation, risk of self-neglect.'*

78. The Tribunal is satisfied on the unchallenged evidence of Dr E that in the process of consulting Patient Q and in the process of prescribing Celsentri and Xeplion that Dr Peters had a duty to conduct an adequate risk assessment of Patient Q. Having considered the handwritten notes provided by Dr Peters the Tribunal finds that no adequate risk assessment was conducted. While Dr Peters recorded information about Patient Q there is no explicit or detailed risk assessment. The Tribunal finds this paragraph 3a(iv) proved.

Paragraphs 3a(v)1 and 3a(v)2

On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to assess whether Patient Q was vulnerable and capacity to consent.

79. The Tribunal noted paragraphs 114, 120, 121 and 189 of Dr E's report, which state:

> *'114. Dr Peters failed to adequately examine and assess Patient Q therefore in my opinion, the standard of care fell seriously below that expected of a reasonably competent Associate Specialist Psychiatrist and there could have been serious life-threatening consequences to Patient Q and the public.*
>
> *120. d. Vulnerability is covered in the section on safety.*
>
> *121. e. Capacity to consent should always be addressed – I cannot find any record of same within Dr Peters' notes.*

189. In my opinion, Dr Peters' apparent presumption of capacity in Patient Q's case was below the standard expected of a reasonably competent Associate Specialist Psychiatrist, but not seriously below, as I must assume that Dr Peters had the clinical skill to make this judgement, in the absence of evidence to the contrary.'

80. The Tribunal is satisfied on the unchallenged evidence of Dr E that in the process of consulting Patient Q and in the process of prescribing Celsentri and Xeplion that Dr Peters had a duty to assess whether Patient Q was vulnerable and had the capacity to consent. The Tribunal notes the duty in Principle 2 HLPGPRCP for a doctor to understand how to identify vulnerable patients and take the appropriate steps to protect them. The Tribunal notes the duty in paragraph 60 of GPPMMD in relation to remote consultations for a doctor to obtain the patient's consent in accordance with the guidelines in paragraphs 20-29. Having considered the handwritten notes provided by Dr Peters the Tribunal finds that he recorded no information about Patient Q's vulnerabilities. However, given the information recorded the Tribunal finds it more likely than not that Dr Peters did some form of capacity assessment. The Tribunal finds paragraph 3a(v)1 proved and paragraph 3a(v)2 not proved.

Paragraphs 3a(vi)1 to 3a(vi)3

On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to contact the following professionals involved in Patient Q's care in the patient's country of residence to verify the patient's clinical history GP, mental health specialist and HIV specialist.

81. The Tribunal noted paragraphs 103, 139, 152 and 221 of Dr E's report, which state:
'103. Dr Peters provided no corroborating source of information regarding Patient Q's care in Egypt (which could only have been verified by the GP, or mental health and HIV specialists). Dr Peters ought to have explained to Patient Q that it was unsafe to prescribe without confirmation of same and further detail of his ongoing treatment. There was no formal mental state examination or risk assessment which should have been part of the clinical assessment. As no medical records were available and in the absence of a referral letter or verification of Patient Q's case details, Dr Peters' prescribing was not safe practice.

139. Dr Peters should not have prescribed to Patient Q without the adequate GMC safeguards in place as above and he should have informed Patient Q of this. In particular, Dr Peters should have made contact with medical professionals and authorities in Egypt to gain documentation ensuring it was appropriate for him to prescribe. Dr Peters should have liaised with HIV services, as this was an area in which Dr Peters had no particular expertise.

152. As discussed above, the GMC ten principles for remote prescribing were not followed and there was no verification of identity or contact made with Egyptian medical professionals. Principles regarding professional registration to prescribe in Egypt were not addressed. Dr Peters was prescribing outside his area of expertise without the input and

approval of HIV specialist services. The ten-principles guidance sets out the following points (for the purpose of safeguarding the patient) and which were not adhered to:

221. The overall standard of care was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist due to the lack of safeguards, lack of contact with treating colleagues, a failure to adhere to the principles of remote prescribing (including the prescribing of a potentially dangerous medication which was outside Dr Peters' area of expertise without liaison with local HIV services).'

82. The Tribunal is satisfied on the unchallenged evidence of Dr E that in the process of consulting Patient Q and before prescribing Celsentri and Xeplion that Dr Peters had a duty to contact Patient Q's GP, Patient Q's mental health specialist and Patient Q's HIV specialist. The Tribunal notes the duty in paras 1 and 14 GMP that a doctor should only issue repeat prescriptions if the doctor has adequate knowledge of the patient's health and are satisfied that the prescribed drugs serve the patient's needs. The Tribunal notes para 33 GMP that where a patient has not been referred to the doctor by that patient's GP, the doctor has a duty to consider whether the doctor has sufficient and reliable information and access to the patient's medical records or other reliable information about the patient's health and other treatments they are receiving. The Tribunal also notes that for remote consultations para 60 obliges a doctor to satisfy himself that he can make an adequate assessment and para 61 states that a doctor may only prescribe remotely when he had adequate knowledge of the patient's health and that the prescribed medicines serve the patient's needs. The Tribunal also notes Principle 4 HLPGPRCP about sharing information with other healthcare providers involved in the patient's care. The Tribunal also notes Principle 6 HLPGPRCP whereby there is a duty to access medical records or verity important information. There is no evidence of any attempt to contact any professional in the handwritten notes provided by Dr Peters. In his submissions Dr Peters accepts he made no such contact. The Tribunal finds it more likely than not that Dr Peters made no attempt to contact any of these professionals. While the Tribunal took into account that all of these professionals are likely to be have been based in Egypt this did not excuse Dr Peters from at least obtaining the names of treating professionals from Patient Q and attempting to contact them and delaying the issue of any prescription until contact had been made or refusing to issue the prescriptions until contact had been made. The Tribunal finds paragraphs 3a(vi)1 to 3a(vi)3 proved.

Paragraph 3a(vii)

On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to discuss alternative treatment options with Patient Q

83. The Tribunal noted paragraph 108 of Dr E's report, which states:

'108. There was no evidence of any discussion with Patient Q within the assessment notes regarding treatment options - though perhaps Dr Peters felt this was not necessary as this was a repeat prescription, despite the fact this was Dr Peters' first consultation with Patient Q and best practice would have been for a full assessment of Patient Q

Paliperidone (Xeplion) is not considered first choice of antipsychotic in HIV patients, according to the Maudsley Prescribing Guidelines, and there could have been discussion of this with Patient Q including consideration for expert pharmacy advice.'

84. The Tribunal is satisfied on the unchallenged evidence of Dr E that in the process of consulting Patient Q and before prescribing Celsentri and Xeplion that Dr Peters had a duty to discuss alternative treatment options for Patient Q. The Tribunal noted the duty in Principle 7 HLPGPRCP for a doctor to give information about all the options available to the patient in way that patient understands. There is no mention of any discussion of alternative treatment options with Patient Q in the handwritten notes provided by Dr Peters. The Tribunal is satisfied that it is more likely than not that Dr Peters failed to discuss alternative treatment options with Patient Q and finds paragraph 3a(vii) proved.

Paragraph 3a(viii)1
On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to tell Patient Q that it would be unsafe to prescribe without first receiving corroborative information about treatment and follow up in Patient Q's own country of residence.

85. The Tribunal noted paragraphs 103 and 136 of Dr E's report, which state

'103. Dr Peters provided no corroborating source of information regarding Patient Q's care in Egypt (which could only have been verified by the GP, or mental health and HIV specialists). Dr Peters ought to have explained to Patient Q that it was unsafe to prescribe without confirmation of same and further detail of his ongoing treatment. There was no formal mental state examination or risk assessment which should have been part of the clinical assessment. As no medical records were available and in the absence of a referral letter or verification of Patient Q's case details, Dr Peters' prescribing was not safe practice.

136. Principle Four requires doctors to explain to their patient that they may only prescribe if it is safe to do so, which Dr Peter's failed to do; the principle states that prescribing may be unsafe if the prescriber does not have sufficient information about the patient's health, or if remote care is unsuitable to meet patient needs. Furthermore – safety of care may be compromised at a later stage if relevant information is not shared with other treatment providers involved in the patient's care. If doctors cannot prescribe due to a safety issue, patients should be signposted to other appropriate services locally. Dr Peters failed to inform either Patient Q or Patient R that it was unsafe to prescribe within the circumstances.'

86. The Tribunal is satisfied on the unchallenged evidence of Dr E that in the process of consulting Patient Q and before prescribing Celsentri and Xeplion that Dr Peters had a duty to tell Patient Q that it would be unsafe to prescribe without first receiving corroborative information about treatment and follow up in Patient Q's own country of residence. The Tribunal took note of the various duties in GMP, GPPMMD and HLPGPRCP outlined above of the duty to

receive corroborative information before prescribing and that it would be unsafe to prescribe without that information and without making arrangements for a follow up in Egypt. The Tribunal notes the handwritten notes provided by Dr Peters in which there is no reference to any relevant discussion about it being unsafe to prescribe without first receiving corroborative information and without any mention of any follow up. The Tribunal finds it more likely than not that Dr Peters failed to comply with his duties. The Tribunal finds paragraph 3a(viii)1 proved.

Paragraph 3a(viii)2
On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to tell Patient Q whether your licence to practice and prescribe within Egypt was valid.

87. The Tribunal noted Dr Peters was prescribing for Patient Q in the UK and considered that it was not necessary for him to have a licence to practice and prescribe within Egypt. The Tribunal found therefore that Dr Peters did not have a duty before prescribing to Patient Q to tell the patient whether his licence to practice and prescribe within Egypt was valid. Accordingly, the Tribunal found paragraph 3a(viii)2 not proved.

Paragraph 3b(i)
On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to liaise with HIV services to ensure Patient Q had follow up and monitoring.

88 The Tribunal noted paragraph 170 of Dr E's report, which states:

> *'170. Dr Peters' standard of care in this respect was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist, particularly with regards to his prescribing Celsentri without liaising with HIV services in Egypt to ensure Patient Q's follow up (monitoring of viral load and other physical medicine screening). This could potentially lead to a life-threatening treatment outcome for Patient Q whose physical health may have already been compromised by whatever event had occurred which warranted the blood transfusion, during which Patient Q was alleged to have been infected with HIV.'*

89. The Tribunal found that this allegation in effect is the same as that set out in Allegation 3(a) (vi) and for the same reasons finds paragraph 3b(i) proved.

Paragraph 3b(ii)1
On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to record (in the alternative to paragraphs 3a and 3bi) having undertaken the actions described at paragraphs 3a and 3bi.

90. The Tribunal having found paragraphs 3a and 3b(i) proved did not consider the alternative in paragraph 3b(ii)1.

Paragraphs 3b(ii)2 to 3b(ii)4
On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to record Patient Q's mental state examination, where the referral for Patient Q originated and your rationale for accepting Patient Q's referral.

91. The Tribunal noted paragraphs 177 (as above) 196 and 112 of Dr E's report, which state

> *'196. In Patient Q's case, Dr Peters' history collation was inadequate and lacking in standard format (please see paragraphs 63 to 76 above). There was no record of whence the referral originated. In this aspect, Dr Peters' care and treatment of Patient Q therefore did not meet GMC guidance for remote prescribing. There was no documentation of assessment of capacity of Patient Q nor is it recorded that Patient Q consented to treatment.*
>
> *112. Dr Peters' addendum outlines the rationale for his decisions; however, in my opinion, Dr Peters' explanations do not fully justify his decision to prescribe without patient safeguards into account – highlighted in particular by the lack of a referral letter or contact with any professional involved in Patient Qs (or Patient R's) care. Dr Peters failed to acknowledge the risks to patients taking these medications and to the public, were they to be diverted to the black market. The HIV medication which should only be available through a specialist HIV unit equipped to monitor patients appropriately (in the same way that availability of* cancer chemotherapy or treatment for Multiple Sclerosis is limited to specialist secondary care units).'

92. The Tribunal is satisfied on the unchallenged evidence of Dr E that in the process of consulting Patient Q and before prescribing Celsentri and Xeplion that Dr Peters had a duty to record Patient Q's mental state examination, where the referral for Patient Q originated and his rationale for accepting Patient Q's referral. The Tribunal has considered the handwritten notes provided by Dr Peters in relation to his consultation with Patient Q. While there is some information about Patient Q's mental state there is no record of where the referral for Patient Q originated and no rationale for accepting Patient Q's referral. The Tribunal is satisfied that it is more likely than not Dr Peters failed to record where the referral for Patient Q originated and failed to record any rationale for accepting Patient Q's referral. On this basis the Tribunal finds paragraphs 3b(ii)2 to 3b(ii)4 proved.

Paragraph 3b(ii)5
On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that before prescribing you failed to record your reasons for prescribing the medication set out in Schedule 2.

93. The Tribunal finds that Dr Peters in the handwritten notes provided did record reasons for prescribing Celsentri and Xeplion. While the Tribunal has concerns as to the adequacy of those reasons it finds that as a matter of fact that reasons were provided. Had the Allegation

included the phrase 'adequate reasons' the Tribunal may have reached a different decision. The Tribunal finds paragraph 3b(ii)5 not proved.

Patient R

Paragraph 4a(i)
On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to verify Patient R's identity.

94. The Tribunal noted paragraph 125 of Dr E's report, which states

> *'125. Principle One was not evidenced in the documentation by Dr Peters, therefore it is unlikely to have been applied to the assessment of Patient R. No verification and identity checks of Patient R were recorded, for example, checking of passport. Was the remote system (Skype, Zoom, etc.,) adequate to allow dialogue without interference and was there adequate interpretation if needed? Safety checks before prescribing include sufficient information about Patient's health being available; there was no evidence of same and this was seriously below the level expected of a competent Associate Specialist Psychiatrist. Patient had a history of homelessness and was particularly vulnerable in this respect.'*

95. This allegation reproduces allegation 3(a)(i) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds Paragraph 4a(i) in relation to Patient R proved.

Paragraphs 4a(ii)1 and 4a(ii)2
On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to obtain consent to access Patient R's medical records and consent to treat Patient R.

96. The Tribunal noted paragraphs 164 and 195 of Dr E's report, which state:

> *'164. There is no record of Patient R consenting to Dr Peters having access to Patient R's GP or his medical records, nor is there a record of Dr Peters seeking consent for same.*
>
> *195. In this aspect, Dr Peters' care and treatment of Patient R therefore did not meet GMC guidance for remote prescribing. There was no documentation of assessment of capacity of Patient R nor is it recorded that Patient R consented to treatment.'*

97. This allegation reproduces allegation 3(a)(ii) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds Paragraphs 4a(ii)1 and 4a(ii)2 in relation to Patient R proved.

Paragraphs 4a(iii)1 to 4a(iii)5

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to take an adequate history, in that you did not make an appropriate enquiry about Patient R's presenting complaint, psychiatric history, medical history, background history and timing of depot medication to determine whether Patient R had relapsed with medication in their system.

98. The Tribunal noted paragraph 54 of Dr E's report, as above.

99. This allegation reproduces allegation 3(a)(iii)1-5 in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraphs 4a(iii)1 to 4a(iii)5 in relation to Patient R proved.

Paragraphs 4a(iii)6(i) to 4a(iii)6(iv)

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to take an adequate history, in that you did not make an appropriate enquiry about Patient R's possible use of alternative remedies, alcohol. Illegal substances, other medications obtained online.

100. This allegation reproduces allegation 3(a)(iii)(6) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraphs 4a(iii)6(i) to 4a(iii)6(iv) in relation to Patient R proved.

Paragraph 4a(iv)

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to conduct an adequate risk assessment of Patient R.

101. The Tribunal noted paragraph 95 of Dr E's report, which states:

> *'95. c. Risk assessment is required as part of any 'adequate clinical assessment', and this is particularly important when prescribing for the first time. Often this information will come with the patient, i.e., suicidality, risk of self-harm, violent thoughts, compliance, substance misuse, absconding risk, risk of arson, sexual, radicalisation, risk of self-neglect.'*

102. This allegation reproduces allegation 3(a)(iv) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraph 4a(iv) in relation to Patient R proved.

Paragraphs 4a(v)1 and 4a(v)2

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to assess whether Patient R was vulnerable and capacity to consent.

103. The Tribunal noted paragraphs 96, 97, 128 and 177 of Dr E's report, which state:

> *'96. d. Vulnerability really comes in the section on safety.*
>
> *97. e. Capacity to consent should always be addressed – I cannot find any record of same within Dr Peters' notes.*
>
> *128. There was no evidence that any significant checks were made on Patient R's background - including forensic history or use of illicit substances, as above there was no documented evidence of any safety checks in place (referral letters were lacking - indeed there was no professional correspondence evidenced from any other clinician). Patient R had a history of IV illicit drug use (no further details of same were elicited at assessment) and was recorded to lack insight [Appendix A, D3]; these are both factors which impact upon Patient R's vulnerability. Dr Peters failed to take steps to ascertain details of Patient R's level of vulnerability.*
>
> *177. In this respect, Dr Peters' prescribing is below the standard expected of a reasonably competent Associate Specialist Psychiatrist, though not seriously below. I opine not seriously below, because this is not clearly a 'must' do procedure as set out in the GMC guidance – rather it is listed as a 'should' action - therefore it is not listed as an overriding duty or a principle. Also Patient R was relapsing but it seems not so badly they could not give a history and make themselves understood; there were no signs that capacity was impaired so he may argue that he presumed Patient R had capacity - consent would be implied in that Patient R came to him for repeat prescriptions. However, advice is clear that in remote prescribing there should be capacity assessment and if the patient lacks capacity, whether remote prescribing is appropriate. Verbal consent is acceptable but GMC Decision making and consent 16 paragraph 6 states 'you should make sure this is recorded in the notes' not must.'*

104. This allegation reproduces allegation 3(a)(v)(1) and (2). Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal finds that there is some inference of vulnerability (e.g. living rough) in the notes. The Tribunal finds it more likely than not that Dr Peters did some form of assessment of vulnerability and capacity. As a result, the Tribunal finds paragraphs 4a(v)1 and 4a(v)2 in relation to Patient R not proved.

Paragraphs 4a(vi)1 to 4a(vi)3

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to contact the following professionals involved in Patient R's care in the patient's country of residence to verify the clinical history, GP, mental health specialist and HIV specialist.

105. The Tribunal noted paragraph 82, 137 and 142 of Dr E's report, which state:

'82. Dr Peters' assessment contained insufficient corroborated information regarding Patient R's treatment and follow up in Egypt, which was only verifiable by direct communication with the GP, and mental health and HIV specialists. He did not include a standard mental state examination or risk assessment.

137. Dr Peters should not have prescribed to Patient R without the adequate GMC safeguards in place as cited above and he should have informed him of this. In particular, Dr Peters should have made contact with medical professionals and authorities in Egypt to gain documentation ensuring it was appropriate for him to prescribe. Dr Peters should have liaised with HIV services, as this was an area outside Dr Peters' expertise.

142. As discussed above, the GMC ten principles for remote prescribing were not followed and there was no verification of Patient R's identity or contact made with Egyptian medical professionals. Principles regarding professional registration to prescribe in Egypt were not addressed. Dr Peters was prescribing outside his area of expertise without the input and approval of HIV specialist services.'

106. This allegation reproduces allegation 3(a)(vi)(1) to (4) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraphs 4a(vi)1 to 4a(vi)3 in relation to Patient R proved.

Paragraph 4a(vii)
On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to discuss alternative treatment options with Patient R.

107. The Tribunal noted paragraph 134 of Dr E's report, which states:

'87. There was no evidence of any discussion in the assessment with Patient R regarding treatment options, though perhaps Dr Peters felt this was unnecessary as this was a repeat prescription. However, it was Dr Peters' first consultation with Patient R and best practice was full assessment of Patient R I note that paliperidone (Xeplion) is not considered first choice of anti-psychotic for HIV patients, according to the Maudsley Prescribing Guidelines13, and discussion of this choice of medication versus alternatives (including expert pharmacy input) was appropriate.'

108. This allegation reproduces allegation 3(a)(vii) in relation to Patient Q. The Tribunal adopts the same reasoning in relation to Patient R save that it finds that in Dr Peters' handwritten notes relating to Patient R there is some reference to alternative treatment options. The Tribunal finds that this is sufficient to suggest that there may have been some discussion of alternative treatment options and therefore finds Paragraph 4a(vii) not proved.

Paragraph 4a(viii)1
On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to tell Patient R that it would be unsafe to prescribe without first receiving corroborative information about treatment, and follow up in Patient R's own country of residence.

109. The Tribunal noted paragraphs 82 and 136 (as above), and 83 of Dr E's report, which state:

> *'83. Dr Peters should have communicated to Patient R that prescribing without this information was unsafe. No medical records were evidenced; to accept the word of a patient without GP or specialist verification when prescribing medication with significant risks associated, particularly to a patient in a foreign country, is not safe practice. Dr Peters justifies his prescribing, alleging Patient R was suffering a relapse of schizophrenia, but this does not justify the lack of any documented efforts to contact any professionals in Egypt concerned with Patient R's care.'*

110. This allegation reproduces allegation 3(a)(viii) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraph 4a(viii)1 in relation to Patient R proved.

Paragraph 4a(viii)2
On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that before prescribing you failed to tell Patient R whether your licence to practise and prescribe within Egypt was valid.

111. The Tribunal noted paragraph 134 of Dr E's report, which states:

> *'134. Dr Peters does not record whether he informed Patient R or Patient Q of his professional registration or whether his licence to practice and prescribe within Egypt was valid; this was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist.'*

112. The Tribunal noted Dr Peters was prescribing for Patient R in the UK. It took account of Dr E's report. The Tribunal's interpretation of the HLPGMP guidance is that it only applied if the patient was overseas and did not apply to overseas patients visiting the UK. The Tribunal considered that it was not necessary for Dr Peters to have a licence to practice and prescribe to patients from Egypt visiting the UK. The Tribunal found therefore that Dr Peters did not have a duty before prescribing to Patient R to tell the patient whether his licence to practice and prescribe within Egypt was valid. Accordingly, the Tribunal found paragraph 4a(viii)2 not proved. The Tribunal notes that Dr Peters accepted that the medication was destined for use in Egypt and the prescribing appeared to be contrary to the spirit of the HLPGMP guidance.

Paragraph 4b(i)

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that you failed to liaise with HIV services to ensure Patient R had follow up and monitoring.

113. The Tribunal noted paragraph 165 of Dr E's report, which states:

> *'165. There is no record of Dr Peters attempting to contact clinicians involved in Patient R's ongoing and follow up care for either his alleged mental disorder or his HIV treatment and care plan. The minimum he should have done would be to communicate with the GP with the consent of Patient R and ideally also the HIV and mental health services to confirm the treatment plan and follow up arrangements.'*

114. This allegation reproduces allegation 3(b)(i) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraph 4b(i) in relation to Patient R proved.

Paragraph 4b(ii)1

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that you failed to record (in the alternative to paragraphs 4a and 4bi) having undertaken the actions described at paragraphs 4a and 4bi.

115. The Tribunal, having found paragraphs 4a and 4b(i) proved, did not consider the alternative in paragraph 4b(ii)1.

Paragraphs 4b(ii)2 and 4b(ii)3

On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that you failed to record Patient R's mental state examination and where the referral for Patient R originated.

116. The Tribunal noted paragraph 98, 93 and 193 of Dr E's report, which state:

> *'93. a. Dr Peters' notes are highly summarised, but there is some indication he enquired at least somewhat about Patient R's mental state, however no formal assessment mental state examination was documented.*
>
> *98. Overall, Dr Peters did not adequately examine or assess Patient R he did not gather any collateral information, explain where his referral for Patient R originated, and did not record his rationale for accepting the referral. Dr Peters' standard of care was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist, as the consequences of same could have been life-threatening.*
>
> *193. In Patient R's case, Dr Peters' history collation was inadequate and lacking in standard format (please see paragraphs 45 to 62 above). There was no record of whence the referral originated.'*

117. This allegation reproduces allegation 3(b)(ii)(2) and (3) in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraphs 4b(ii)2 and 4b(ii)3 in relation to Patient R proved.

Paragraphs 4b(ii)4 and 4b(ii)5
On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that you failed to record your rationale for accepting Patient R's referral and your reasons for prescribing the medication set out in Schedule 3.

118. The Tribunal noted paragraph 98 (above) of Dr E's report.

119. This allegation reproduces allegation 3(b)(ii)4 and 3(b)(ii) 5 in relation to Patient Q. Having considered the handwritten notes relating to Patient R provided by Dr Peters the Tribunal adopts the same reasoning as for Patient Q and for the same reasons finds paragraphs 4b(ii)4 proved and 4b(ii)5 not proved.

All Patients

Paragraph 5
When prescribing Celsentri to Patients A-R as described in Schedules 1-3, you did so outside the limits of your competence.

120. The Tribunal noted paragraphs 137, 139, 142, 152 and 221 of Dr E's report, which state:

> *'137. Dr Peters should not have prescribed to Patient R without the adequate GMC safeguards in place as cited above and he should have informed him of this. In particular, Dr Peters should have made contact with medical professionals and authorities in Egypt to gain documentation ensuring it was appropriate for him to prescribe. Dr Peters should have liaised with HIV services, as this was an area outside Dr Peters' expertise.*
>
> *139. Dr Peters should not have prescribed to Patient Q without the adequate GMC safeguards in place as above and he should have informed Patient Q of this. In particular, Dr Peters should have made contact with medical professionals and authorities in Egypt to gain documentation ensuring it was appropriate for him to prescribe. Dr Peters should have liaised with HIV services, as this was an area in which Dr Peters had no particular expertise.*
>
> *142. As discussed above, the GMC ten principles for remote prescribing were not followed and there was no verification of Patient R's identity or contact made with Egyptian medical professionals. Principles regarding professional registration to prescribe in Egypt were not addressed. Dr Peters was prescribing outside his area of expertise without the input and approval of HIV specialist services. The ten-principles guidance sets out the following points that were not adhered to:*

152. As discussed above, the GMC ten principles for remote prescribing were not followed and there was no verification of identity or contact made with Egyptian medical professionals. Principles regarding professional registration to prescribe in Egypt were not addressed. Dr Peters was prescribing outside his area of expertise without the input and approval of HIV specialist services. The ten-principles guidance sets out the following points (for the purpose of safeguarding the patient) and which were not adhered to:

221. The overall standard of care was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist due to the lack of safeguards, lack of contact with treating colleagues, a failure to adhere to the principles of remote prescribing (including the prescribing of a potentially dangerous medication which was outside Dr Peters' area of expertise without liaison with local HIV services).'

121. This allegation is in substance the same as Allegation 1(a) in relation to Mimpara. The Tribunal finds that the same reasoning for finding Allegation 1(a) proved applies to the prescribing of Celsentri to Patients A. The Tribunal finds it more likely than not that Dr Peters had no specialist training or expertise in the use and prescribing of Celsentri and for the same reasons as applied to the use and prescribing of Mimpara finds this paragraph 5 proved.

Paragraph 6a

Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to take reasonable steps to contact the clinician who had previously prescribed to Patients A-R, Dr S, in order to ascertain whether the medication you were prescribing was necessary and appropriate.

122. The Tribunal noted paragraph 20 of Dr E's report, which states:

'20. Access to a patient's verified medical history is crucial to safe assessment, treatment, and prescribing, therefore Dr Peters should have made a concerted and documented attempt to contact the original prescriber. No medical records or referral letters for any of the eighteen patients to whom Dr Peters prescribed medication are included in Dr Peters' evidence.'

123. The Tribunal found this allegation was essentially the same as allegation 3(a)(vi) and 4(a)(vi) in relation to the duty on Dr Peters to obtain relevant information in order to prescribe safely. For the same reasons as outlined for allegation 3(a)(vi) the Tribunal finds that there was a duty on Dr Peters to take reasonable steps to contact Dr S and that he failed to do so. Dr S confirms that he had no contact from Dr Peters. Dr Peters accepts he did not contact or make any effort to contact Dr S. The Tribunal therefore finds paragraph 6a proved.

Paragraph 6b

Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to check the Care and Quality Commission status of Dr S's clinical practice.

124. The Tribunal noted paragraph 26 of Dr E's report, which states:

'26. A brief check on Dr S' CQC status (he was the sole GP running a medical practice which was deemed inadequate and put in 'special measures' in 2017), and the fact that he was not on the Specialist Register should have raised a red flag regarding whether Dr S had the necessary expertise to prescribe medicines which are normally prescribed by Secondary care or Tertiary care specialist services, and whether Dr S' medical practice was likely to have ever had the capacity to manage the monitoring necessary for patients on the medications prescribed [TDB comment: was subsequently 'erased' from the GMC Medical Register due to the significant risk of harm associated with his prescribing practice – 'The allegation that has led to hearing can be summarised as that between November 2013 and October 2016 he inappropriately prescribed medication to a number of patients without having the necessary specialist expertise and/or entering into appropriate shared care agreements. The circumstances of the prescribing were unusual. The prescriptions were written for patients overseas via a pharmacy in the UK. It is alleged that failed to provide adequate advice to the patients for whom prescriptions were written and failed to make appropriate and adequate clinical records. It is also alleged that these failings amount to misconduct on the part of Dr S.'

125. The Tribunal can find no duty on a doctor to check the status of a previously prescribing doctor or of his clinical practice with the CQC or at all. The Tribunal finds that Dr Peters was presented with what appeared to be valid prescriptions issued by a Dr S with the name and address of the surgery. The Tribunal is not satisfied that there was any failure by Dr Peters to check the status of Dr S or of Dr S's clinical practice and finds Paragraph 6b not proved.

Paragraph 6c(i)

Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to ensure that you had the appropriate registration for prescribing to patients in Egypt.

126. The Tribunal noted paragraph 152 of Dr E's report, which states:

'152. As discussed above, the GMC ten principles for remote prescribing were not followed and there was no verification of identity or contact made with Egyptian medical professionals. Principles regarding professional registration to prescribe in Egypt were not addressed. Dr Peters was prescribing outside his area of expertise without the input and approval of HIV specialist services. The ten-principles guidance sets out the following points (for the purpose of safeguarding the patient) and which were not adhered to:'

127. The Tribunal finds that it was more likely than not that Dr Peters prescribed in the UK to patients who were in the UK (albeit resident in Egypt). The Tribunal finds that the premise of this allegation of prescribing to patients in Egypt is unfounded and finds paragraph 6c(i) not proved.

Paragraph 6c(ii)

Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to ensure that you had the appropriate adequate indemnity insurance to do so.

128. The Tribunal noted paragraphs 227 and 170 of Dr E's report, which state:

227. Dr Peters' should provide evidence that he had the necessary registration and indemnity insurance to prescribe for patients remotely in Egypt.

170. There is no evidence that Dr Peters followed any of this guidance, as stated above, there is no documentation that any remote assessment (either by video link or telephone) took place. There is no evidence that Dr Peters either sought contact, or contacted, the usual treating clinicians involved in Patient A's care to ensure Patient A's condition was monitored. There is no evidence that Dr Peters verified that he had adequate insurance/indemnity in place to cover his practice in treating Patient A or any documentation as to whether Dr Peters required to be registered in Egypt for compliance in prescribing.

129. While the Tribunal finds that it was more likely than not that Dr Peters prescribed in the UK to patients who were in the UK (albeit resident in Egypt). Dr Peters admitted in his email dated 6 September 2022 that he had no indemnity insurance for prescribing as a GP (outside of his NHS practice) and therefore finds paragraph 6c(ii) proved.

The Tribunal's Overall Determination on the Facts

130. The Tribunal has determined the facts as follows:

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

Patients A-P

1. Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that:

a. before prescribing, you failed to assess the patient(s) at all;
Determined and found proved

Mimpara

b. in respect of Patients A-I, you prescribed Mimpara, and you:

i. did so outside the limits of your competence without conferring with the relevant specialists;
Determined and found proved

ii. failed to, before prescribing, establish the relevant patient's:

1. blood pressure;
Determined and found proved

2. pulse rate;

Determined and found proved

3. heart sounds;
Determined and found proved

4. most recent ECG test result;
Determined and found proved

5. most recent blood test result for:
Determined and found proved

i. serum calcium levels;
Determined and found proved

ii. parathyroid hormone levels;
Determined and found proved

iii. failed to arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1bii1-5 above;
Determined and found proved

Celsentri

c. you prescribed Celsentri and failed to:

i. obtain, before prescribing, a recent white cell count/viral load result for the patient;
Determined and found proved

ii. arrange for the prompt follow up monitoring of the patient's white cell count/viral load;
Determined and found proved

iii. have contact and guidance from specialist HIV services when prescribing Celsentri;
Determined and found proved

iv. check for drug interactions;
Determined and found proved

v. liaise with HIV services to ensure the patient had follow up and monitoring;
Determined and found proved

Xeplion

d. you prescribed Xeplion and failed to:

i. establish, before prescribing, the relevant patient's:

1. blood pressure;
Determined and found proved

2. pulse rate;

Determined and found proved

3. heart sounds;

Determined and found proved

4. height;
Determined and found proved

5. weight;
Determined and found proved

6. ECG;
Determined and found proved

ii. arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1di;
Determined and found proved

iii. ascertain the mental state of the patient before prescribing;
Determined and found proved

iv. check for drug interactions;
Determined and found proved

v. review the patient's recent metabolic status;
Determined and found proved

vi. record any handover to the patient's usual treating clinician(s);
Determined and found proved

e. you prescribed Celsentri and Xeplion together, without arranging for the monitoring of any side effects.
Determined and found proved

2. Your record keeping was inadequate in that:

a. (in the alternative to paragraph 1bii-1biii) when prescribing Mimpara to Patients A-I, as described in Schedule 1, you failed to record having undertaken the actions referred to in paragraph 1bii-1biii;
Not considered in the alternative

b. when prescribing to Patients A-P as described in Schedule 1, you failed to record:

i. (in the alternative to paragraph 1a) an adequate assessment of the patient;
Not considered in the alternative

ii. (in the alternative to paragraph 1c-e) having adequately undertaken the actions referred to in paragraph 1c-e;
Not considered in the alternative

c. in respect of Patient I, you failed to document your reasons for initiating treatment with Mimpara.
Determined and found proved

Patient Q

3. On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that:

a. before prescribing you failed to:

i. verify Patient Q's identity;
Determined and found proved

ii. obtain consent to:

1. access Patient Q's medical records;
Determined and found proved

2. treat Patient Q;
Determined and found proved

iii. take an adequate history, in that you did not make an appropriate enquiry about Patient Q's:

1. presenting complaint;
Determined and found proved

2. psychiatric history;
Determined and found proved

3. medical history;
Determined and found proved

4. background history;
Determined and found proved

5. timing of depot medication to determine whether Patient Q had relapsed with medication in their system;
Determined and found proved

6. previous blood transfusion;
Determined and found proved

7. possible use of:

i. alternative remedies;
Determined and found proved

ii. alcohol;
Determined and found proved

iii. illegal substances;
Determined and found proved

iv. other medications obtained online;
Determined and found proved

iv. conduct an adequate risk assessment of Patient Q;
Determined and found proved

v. assess:

1. whether Patient Q was vulnerable;
Determined and found proved

2. Patient Q's capacity to consent;
Not proved

vi. contact the following professionals involved in Patient Q's care in the patient's country of residence to verify the patient's clinical history:

1. GP;
Determined and found proved

2. mental health specialist;
Determined and found proved

3. HIV specialists;
Determined and found proved

vii. discuss alternative treatment options with Patient Q;
Determined and found proved

viii. tell Patient Q:

1. that it would be unsafe to prescribe without first receiving corroborative information about treatment and follow up in Patient Q's own country of residence;
Determined and found proved

2. whether your licence to practice and prescribe within Egypt was valid;
Not proved

b. you failed to:

i. liaise with HIV services to ensure Patient Q had follow up and monitoring;
Determined and found proved

ii. record:

1. (in the alternative to paragraphs 3a and 3bi) having undertaken the actions described at paragraphs 3a and 3bi;
Not considered in the alternative

2. Patient Q's mental state examination;
Determined and found proved

3. where the referral for Patient Q originated;
Determined and found proved

4. your rationale for accepting Patient Q's referral;
Determined and found proved

5. your reasons for prescribing the medication set out in Schedule 2.
Not proved

Patient R

4. On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that:

a. before prescribing you failed to:

i. verify Patient R's identity;
Determined and found proved

ii. obtain consent to:

1. access Patient R's medical records;

Determined and found proved

2. treat Patient R;
Determined and found proved

iii. take an adequate history, in that you did not make an appropriate enquiry about Patient R's:

1. presenting complaint;
Determined and found proved

2. psychiatric history;
Determined and found proved

3. medical history;
Determined and found proved

4. background history;
Determined and found proved

5. timing of depot medication to determine whether Patient R had relapsed with medication in their system;
Determined and found proved

6. possible use of:

i. alternative remedies;
Determined and found proved

ii. alcohol;
Determined and found proved

iii. illegal substances;
Determined and found proved

iv. other medications obtained online;
Determined and found proved

iv. conduct an adequate risk assessment of Patient R;
Determined and found proved

v. assess:

1. whether Patient R was vulnerable;
Not Proved

2. Patient R's capacity to consent;
Not Proved

vi. contact the following professionals involved in Patient R's care in the patient's country of residence to verify the clinical history:

1. GP;
Determined and found proved

2. mental health specialist;
Determined and found proved

3. HIV specialists;
Determined and found proved

vii. discuss alternative treatment options with Patient R;
Not proved

viii. tell Patient R:

1. that it would be unsafe to prescribe without first receiving corroborative information about treatment, and follow up in Patient R's own country of residence;
Determined and found proved

2. whether your licence to practise and prescribe within Egypt was valid;
Not proved

b. you failed to:

i. liaise with HIV services to ensure Patient R had follow-up and monitoring;
Determined and found proved

ii. record:

1. (in the alternative to paragraphs 4a and 4bi) having undertaken the actions described at paragraphs 4a and 4bi;
Not considered in the alternative

2. Patient R's mental state examination;
Determined and found proved

3. where the referral for Patient R originated;
Determined and found proved

4. your rationale for accepting Patient R's referral;
Determined and found proved

5. your reasons for prescribing the medication set out in Schedule 3.
Not proved

<u>All patients</u>

5. When prescribing Celsentri to Patients A-R as described in Schedules 1-3, you did so outside the limits of your competence.
Determined and found proved

6. Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to:

a. take reasonable steps to contact the clinician who had previously prescribed to Patients A-R, Dr S, in order to ascertain whether the medication you were prescribing was necessary and appropriate;
Determined and found proved

b. check the Care and Quality Commission status of Dr S's clinical practice;
Not proved

c. ensure that you had the appropriate:

i. registration for prescribing to patients in Egypt;
Not proved

ii. adequate indemnity insurance to do so.
Determined and found proved

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

DETERMINATION ON IMPAIRMENT - 25/10/2022

1. 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 Peters' fitness to practise is impaired by reason of misconduct.

Submissions

2. On behalf of the GMC, Mr Jackson provided written submissions on impairment. The following is a summary of those submissions.

3. Mr Jackson referred the Tribunal to paragraph 22 of its facts determination, and the findings that Dr Peters was prescribing without any adequate assessment of the patients, and in relation to certain drugs (e.g. Mimpara,) he was prescribing outside his competence as a doctor, and submitted that these were two very serious overarching failures.

4. Mr Jackson reminded the Tribunal that it found it more likely than not that Dr Peters:

    1. In prescribing Mimpara and Celsentri was working outside the limits of his competence in breach of para 14 GMP and paras 1 and 57 GPPMDD

    2. In prescribing Mimpara, Celsentri and Xeplion acted without adequate knowledge of the health of each of the patients and without consulting specialist colleagues and without checking that drugs prescribed were compatible with each other and with any other treatments the patient was receiving in breach of para 16 GMP and paras 1, 14 and 61 GPPMDD

    3. In relation to Patients A to P failed to make any records of the reasons for the repeat prescriptions in breach of paras 19 and 21 GMP and in the cases of Patients Q and R failed to make adequate clinical records in breach of para 21 GMP

    4. In relation to all of the patients failed to take an adequate history in breach of para 21 GPPMDD

    5. Not being the GP for any of the patients failed to check the completeness and accuracy of information in breach of paras 32 and 33 GPPMDD

    6. In repeating the prescriptions of Dr S failed to satisfy himself that each of the prescriptions was needed, appropriate and within the limits of his competence in breach of para 37 GPPMDD

7. Failed to ensure that suitable arrangements were in place for monitoring, follow up and reviews, taking into account each of the patient's needs and any risks arising from the medicines in breach of paras 55 and 56 GPPMDD

8. In repeating the same levels of medication prescribed by Dr S failed to consider the correct dose for each patient in breach of paras 57 and 59 GPPMDD

9. In relation to Patients R and Q failed to undertake an adequate clinical assessment or verify important information in breach of Principle 6 HLPGPRCP

10. In relation to Patients R and Q failed to keep notes that fully explained and justified the decisions he made in breach of Principle 9 HLPGPRCP

11. In relation to Patients R and Q failed to consider the limitations of remote consultations and the suitability of prescribing remotely each of the medicines contrary to the guidance following the 10 principles in HLPGPRCP

5. Mr Jackson referred the Tribunal to some of the principal authorities that deal with the issue of what may constitute 'impairment', in the context of fitness to practise. He referred the Tribunal to the case of *Cheatle v GMC [2009] EWHC 645 (Admin*). [Mr Justice Cranston] He stated that the GMC seek only to place before the Tribunal a single reference from this case, because it follows on from Mr Justice Mitting's judgment in *Zygmunt v General Medical Council* to which I have just made reference. He said that the relevant quote picks up on the point about the need for the Tribunal, in the context of the issue of 'impairment', to look at the issue of the past when looking at the issue of the future. Paragraph 21 of his judgment, Cranston J stated:

> *'There is clear authority that in determining impairment of fitness to practise at the time of the hearing, regard must be had to the way the person has acted or failed to act in the past. As Sir Anthony Clarke MR put it in Meadow v General Medical Council [2006] EWCA Civ 1390:*
> *…*
> *In short, the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoings, but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward, not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past (para 32).'*

6. Mr Jackson also stated that the GMC also makes reference to the more recent decision of the case of *Yeong v The General Medical Council [2009] EWHC 1923 (Admin),* this being a judgment from Mr Justice Sales, in the Administrative Court, which is a case that also related to conduct. He stated that Dr Yeong was a specialist in obstetrics and gynaecology, and he fell into error in terms of having an inappropriate sexual relationship with a patient. Mr Jackson referred the Tribunal to paragraphs 50 and 51, which state:

'First, in my judgment, the overarching function of the GMC as set out in s. 1(1A) of the Act informs the meaning of impairment of fitness to practise by reason of misconduct in s. 35C(2), so that under s. 35C(2) and s. 35D the FTPP (acting on behalf of the GMC) [Tribunal] is entitled to have regard to the public interest in the form of maintaining public confidence in the medical profession generally and in the individual medical practitioner when determining whether particular misconduct on the part of that medical practitioner qualifies as misconduct which currently impairs the fitness to practise of that practitioner. Where a medical practitioner violates such a fundamental rule governing the doctor/patient relationship as the rule prohibiting a doctor from engaging in a sexual relationship with a patient, his fitness to practise may be impaired if the public is left with the impression that no steps have been taken by the GMC to bring forcibly to his attention the profound unacceptability of his behaviour and the importance of the rule he has violated. The public may then, as a result of his misconduct and the absence of any regulatory action taken in respect of it, not have the confidence in engaging with him which is the necessary foundation of the doctor/patient relationship. The public's confidence in engaging with him and with other medical practitioners may be undermined if there is a sense that such misconduct may be engaged in with impunity'. [Counsel's underlining here and below]

'Secondly, where a FTPP [Tribunal] considers that fitness to practise is impaired for such reasons, and that a firm declaration of professional standards so as to promote public confidence in that medical practitioner and the profession generally is required, the efforts made by the practitioner to address his problems and to reduce the risk of recurrence of such misconduct in the future may be of far less significance than in other cases, such as those involving clinical errors or incompetence. In the former type of case, the fact that the medical practitioner in question has taken remedial action in relation to his own attitudes and behaviour will not meet the basis of justification on which the FTPP considers that a finding of impairment of fitness to practise should be made. This view is also supported to some degree by the judgment of McCombe J in Azzam at [51] (distinguishing the case before him, which involved clinical errors, in respect of which evidence of remedial steps and improvement was relevant, from a case involving "a rape or misconduct of that kind", in relation to which – by implication – such evidence might be less significant)'.

7. Mr Jackson submitted that the key issue for the Tribunal is whether Dr Peters' misconduct renders him currently unfit to practice; and/or whether he currently unfit to practice for the reasons set out at paragraph 50 of Yeong detailed above, in terms of the need for the GMC to set and maintain professional standards and the public's confidence in the medical profession.

8. Mr Jackson referred the Tribunal to more recent case of *Council Health Care Regulatory Excellence v NMC and Grant [2011] EWHC 927 QBD (Admin)* and the judgment of Mrs Justice Cox DBE, in which the issue of the public interest considerations was determinative of the appeal against what was considered an unduly lenient sanction. Starting at paragraph 70 of her Ladyship's judgment, which states:

*'20. **However it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of this section of his judgment at paragraph 62, namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession**.*
[Counsel's highlighting]

21. This need to have regard to the wider public interest in determining questions of impairment of fitness to practise was also referred to by Goldring J in R (on the Application of Harry) v. General Medical Council [2006] EWHC 3050 (Admin) and by Mitting J in Nicholas-Pillai, where he held that the Panel were entitled to take into account the fact that the practitioner had contested critical allegations of dishonest note-keeping, observing that:

> *"[19] In the ordinary case such as this, the attitude of the practitioner to the events which give rise to the specific allegations against him is, in principle, something which can be taken into account either in his favour or against him by the panel, both at the stage when it considers whether his fitness to practise is impaired, and at the stage of determining what sanction should be imposed upon him.'*

9. Mr Jackson stated that the history of so called 'public interest' considerations, as addressed in the case of Yeong v SMC above, goes back to the Medical Act 1983, which is of course, the statute which created the GMC, and provides for medical education, licensing and registration, together with fitness to practise and professional conduct.

10. Mr Jackson referred the Tribunal to Section 1(1) and Section 1(1A), which sets out the objectives of the GMC as follows:

'(1A) The over-arching objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public.'

11. He stated that in 2015, a section 1(1B) was added to flesh out this over-arching objective as follows:

'(1B) The pursuit by the General Council of their over-arching objectives involves the pursuit of the following objectives-

(a) to protect, promote and maintain the health, safety and well-being of the public,

(b) to promote and maintain public confidence in the medical profession, and

(c) to promote and maintain proper professional standards and conduct for members of that profession.'

12. Mr Jackson submitted that the statutory framework identified within the judgments referred to above (and particularly Sales J's), the Tribunal, when it is considering whether or not Dr Peters' fitness to practise is currently impaired it is required to look forward, rather than backward. He noted that what has happened in the past, and the doctor's response to his past misconduct, if any, will inform the Tribunal about the doctor's insight, if any, and his current fitness to practise.

13. Mr Jackson submitted that in all the circumstances, and for the reasons set out above, the Tribunal should now find that Dr Peters' Fitness to Practise is currently impaired by reason of the scale and duration his repeated serious misconduct.

The Relevant Legal Principles

14. 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.

15. 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 then whether the finding of that misconduct which was serious, could lead to a finding of impairment.

16. The Tribunal must determine whether Dr Peters' fitness to practise is impaired today, taking into account his 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.

17. The Tribunal took account of Mr Jackson's submissions, Dr Peters' statements and emails and the relevant case law.

The Tribunal's Determination on Impairment
Misconduct

18. The Tribunal found that in relation to prescriptions issued to Patients A to R, Dr Peters breached the principles in paragraphs 14, 16, 19 and 21 of Good Medical Practice (the 2013 edition) (the GMP) and it determined that his actions represented a serious departure from those principles. It also found that Dr Peters failed to follow the guidance in Good Practice in Prescribing and Managing Devices' (March 2013) (the 'GPPMDD') set out at paragraphs 1, 5, 14, 21, 32, 33, 37, 51, 55, 56, 59-61 and 64 and that again there were serious departures from this guidance.

19. In relation to Dr Patients R and Q in addition to the serious failures outlined above Dr Peters failed to follow the ten principles set out in 'High level Principles for good practice in remote consultations and prescribing' (the 'HLPGPRCP') which was published on 8 November 2019. The Tribunal found these to be serious failures to follow this guidance.

20. The Tribunal noted that Dr Peters was not trained as a GP, nor was he on any GP performers list and did not have indemnity insurance. It noted the scale and duration of Dr Peters prescribing and took account of Dr E's concerns about the manner in which Dr Peters prescribed the medications, in particular Mimpara and Celsentri, whereby inappropriate prescribing could result in serious injury or death.

21. The Tribunal agreed with Dr E's conclusions in all four of his reports that Dr Peters' performance fell seriously below the standard expected of a staff grade psychiatrist. This conclusion is reached in each of the four reports provided by Dr E. Dr E's conclusions are summarised in his final report of 14 October 2022:

> *'Dr Peters' prescribing practice involving Patients A-R, which I find seriously below the standard expected of an Associate Specialist Psychiatrist* (Paragraph 26, 14 October 2022 report).
>
> *To reiterate, Dr Peters repeatedly prescribed outside his area of expertise, did not adhere to GMC prescribing guidelines, and issued prescriptions without indemnity insurance in place. His practice was unsafe, as has been outlined in some detail in my previous reports*. (Paragraph 41)
>
> '*To reiterate and summarise my opinion as stated in my previous reports dated 19 May 2021, 4 April 2022, and 18 August 2022, Dr Peters' prescribing to Patients A-R was seriously below the standard expected of a reasonably competent Associate Specialist Psychiatrist (i.e., not on the Specialist Register).'*
>
> *'in my opinion, Dr Peters' overall standard of care was seriously below that expected of a reasonably competent Associate Specialist Psychiatrist*'. (Paragraph 52)'

22. The Tribunal was of the opinion Dr Peters' actions would be considered deplorable by members of the medical profession. The Tribunal concluded that Dr Peters' conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to serious misconduct.

Impairment

23. The Tribunal having found that the facts found proved amounted to misconduct, went on to consider whether, as a result of that misconduct Dr Peters' fitness to practise is currently impaired.

24. The Tribunal was mindful that whilst evidence of good character and testimonials were relevant to credibility and propensity the significance of such evidence ought not to be overstated and should not detract from the primary focus on the evidence directly relevant to the alleged wrongdoing: *Martin v Solicitors Regulation Authority [2020] EWHC 3525 (Admin).* The

Tribunal took into accounts Dr Peters' good character and the testimonials he had provided in that light.

25. The Tribunal considered the guidance provided by Dame Janet Smith on impairment in the *Fifth Shipman Report* which was adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin.* A doctor can only be found to have been impaired if he/she:

> *'(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 committed a breach (other than one which is trivial) of one of the fundamental tenets of the medical profession and/or is liable to do so in the future; and/or*
> *(d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

26. The Tribunal was satisfied that (a),(b) and (c) are engaged

27. The Tribunal considered the matter of impairment in light of Dr Peters' insight and remediation and applied the test in *Cohen v General Medical Council [2008] EWHC 581 (Admin),* where Mr Justice Silber ruled that at the impairment stage, a Tribunal ought to take account of evidence and/or submissions from both the doctor and the GMC that the doctor's failings and asked:

> *1. Are the proven concerns about the doctor's behaviour, skills, performance or health remediable?*
> *2. Have the concerns about the doctor's behaviour, skills, performance or health been remedied?*
> *3. Are the concerns about the doctor's behaviour, skills, or performance likely to be repeated?*

28. The Tribunal asked if Dr Peters had demonstrated insight by:

> 1. Demonstrating that he had reflected on his own performance or conduct and understood what went wrong
> 2. Accepted he should have behaved differently in the circumstances
> 3. Demonstrated that he had understanding the impact or potential impact of his performance or conduct
> 4. Demonstrated empathy for any individual involved
> 5. Taken timely steps to remediate and identify how he would act differently in the future to avoid similar issues arising.

29. The Tribunal has borne in mind the case of *Sayer v GOC 2021 EWHC 370 Admin* where it was held that it is proper to take into account, when weighing up insight, the registrant's understanding of and attitude towards the underlying allegation. In the assessment of considering current insight, it is open to the Tribunal to consider the background to the differing accounts provided.

30. The Tribunal noted the responses from Dr Peters made in his statement and e-mail correspondence and found that Dr Peters lacked insight into his misconduct. In his e-mail of 1 July 2021, he stated:

> *'I just want to write to you and your team that my action in writing the prescription for these two gentlemen was done in good faith to help them because it was at the peak of the pandemic and I assumed their diagnosis to be genuine which looking back was a big mistake.'*

31. In Dr Peters' e-mail of 19 July 2021, he said:

> *'My actions in writing those 2 prescriptions was totally in good faith to help someone at their own time of need which looking back caused me to step out of line with the gmc guidelines that I hold and respect dearly. I promise never to step out of line in this manner. I just wish to be given another chance to carry on in rendering services to humanity as I have been doing all these years'.*

32. In Dr Peters' statement of 24 July 2022 he stated in reference to Dr E's reports:

> *'In this, it appears that he has not factored in the fact that all I was doing is providing repeat prescription for persons on holiday or passing through the UK who required medications at this time to keep them well and who if not given these medications may suffer deterioration in their physical health or suffer mental breakdown. He also did not factor in that I was only writing a repeat prescription; copying prescriptions that were written by a UK based consultant physician.'*
>
> *'Regarding the appropriateness, I can only reiterate the fact that the prescriptions I wrote were repeat prescriptions based on existing prescription that has been written by another doctor whom I was told is no longer in practice. They were not prescriptions I initiated rather; they were repeats to ensure that the chain of compliance was not broken.'*
>
> *'The safeguards I utilised was the assurance that initial prescriptions were done by a duly registered UK practitioner who had followed the lead of physicians in Egypt who already established the client on the medications with benefits and there was no report of any side effects'.*
>
> *'It was not practicable to contact physicians in Egypt but in taking steps to obtain copies of previous prescription done for them by a UK registered doctor and establishing that they were taking the medication and ensuring that I did not go beyond the dose they were*

established on. A prescription from a UK based doctor is a proof that I made effort to reach out to their usual Doctor.'

'I make an undertaking to attend any relevant courses, seminars, workshops and read material that promote /teach safe prescribing and I state categorically that I have abided by the directive, not to do any further private prescription since April 2020.'

33. In Dr Peters e-mail of 10 October 2022 he said:

'I as a person, do have a caring heart and loves to help whenever I am able. I have come to the end of my career, and I have no regrets for helping these my people.' I have had a good life, like I said, I have no regrets and if I am given the chance, I will still love to help my fellow human being with my knowledge and skill. I do not feel there is anything wrong in helping someone else. Of course, having gone through the horrors of GMC INVESTIGATION in the last 2 years +. I would not write remote private prescriptions ever again.'

'In summary, sometimes you may have evidence which are glaring like the prescriptions I wrote, there may be witness statements which are filled with fabrications to suit their purpose and facts which are lopsided to make a point but the TRUTH shall always prevail.' Evidence , witness statements and facts from experts is not always the truth. The truth in my case investigation is that NO ONE,. NOT EVEN ONE OF THE MEMBER OF THE PUBLIC WAS HARMED BY MY PRESCRIPTION. I have not willingly gone out to put the public health in danger for a single day in my 29 years of practice in this country. And coincidentally all the people I wrote private prescription for are having a good time in Egypt.'

34. The Tribunal agreed with Dr E that Dr Peters lacked insight. Dr E reported at paragraph 22 of his 14 October 2022 report of Dr Peters comments '*All the medications were not stimulants or Psychedelic in any shape or form*' and '*All the medications are not addictive and as such were not sold or bought from the black market*:

'Dr Peters amply evidences that he completely misses the salient point, which is that he prescribed specialist medications outside his expertise (Mimpara and Celsentri), which may be life threatening to patients if not properly prescribed and monitored by specialists, and that he failed to follow GMC guidance in terms of accessing information regarding Patients A-R's mental and physical health status, and failed to arrange follow up monitoring of same.'

35. The Tribunal finds that Dr Peters' misconduct is capable of remediation. However, in the Tribunal's judgement Dr Peters had taken no steps to address his repeated and sustained failures to follow basic guidance and procedures. The Tribunal found that Dr Peters had failed to engage in the hearing so was unable to assist it with insight and remediation. The Tribunal noted that Dr Peters had promised not to issue any more prescriptions, promised to do any appropriate courses and had applied unsuccessfully to voluntarily erase himself from the medical register. The Tribunal noted that Dr Peters had failed to fully accept his failings, expressed little remorse,

expressed limited insight, and had failed to make any efforts to do any work to remediate his failings.

36. The Tribunal found that Dr Peters acted as a GP which was outside his area of competence and expertise and has demonstrated no empathy nor recognised that these patients were put at enormous risk. It found that Dr Peters has failed to sufficiently demonstrate that he has reflected on his performance and conduct and understood what went wrong. Whilst Dr Peters stated that he would not do this again the Tribunal considered that he has not accepted that he could have behaved differently in the circumstances. The Tribunal considered that Dr Peters has failed to demonstrate that he understands the impact or potential impact of his conduct had on the patients. Dr Peters has failed to demonstrate any empathy for the patients nor demonstrated remorse. Dr Peters has provided no evidence to the Tribunal that he has taken any steps to remediate and identify how he would act differently in the future to avoid similar issues arising.

37. Taking Dr Peters' incomplete insight and remediation into account, the Tribunal could not be satisfied that there was no risk of repetition.

38. Finally, the Tribunal considered the overarching objective. It took account of the serious nature of Dr Peters' misconduct, the potential impact of his actions on public trust in the profession, his level of insight and remediation and the ongoing risk of repetition. The Tribunal concluded that Dr Peters' misconduct would undermine the overarching objective.

39. The Tribunal determined that a finding of impairment was required 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.

40. The Tribunal has therefore determined that Dr Peters' fitness to practise is impaired by reason of misconduct.

Determination on Sanction - 26/10/2022

1. Having determined that Dr Peters' fitness to practise is impaired by reason of 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.

Submissions

2. On behalf of the GMC, Mr Jackson provided written submissions for the Tribunal. The following is a summary of those submissions. Mr Jackson referred the Tribunal to the relevant paragraphs in the Sanction Guidance (November 2020) (the SG). He stated that Paragraph 4 is an important paragraph because it makes clear that:

'When deciding whether to impose a sanction, tribunals must have regard to the

overarching objective of protecting the public (see paragraph 14).'

3. Mr Jackson stated that Paragraph 6 of SG, makes clear that the guidance has to be fair in terms of equality and diversity. He also stated that Paragraph 7 makes clear that henceforth all restrictions or requirements placed on a doctor (except those relating solely to a doctor's health) are published on the GMC website. He further stated that Paragraph 8 informs registrants that any action taken on a doctor's registration is also sent to relevant organisations, both within and outside the UK, such as overseas regulators.

4. Mr Jackson referred the Tribunal to paragraphs 9 of Good Medical Practice (2013) (GMP). Paragraph 9 sets out what is expected of doctors in terms of expected professional standards.

'9 Good medical practice and its explanatory guidance define what makes a good doctor by setting out the professional values, knowledge, skills and behaviour required of all doctors working in the UK. A wide range of people, including patients, doctors, employers and educators are consulted in the development of the standards and guidance.'

5. Mr Jackson stated that Paragraph 10 explains that GMP covers fundamental aspects of a doctor's role, including:

'a. working in partnership with patients and treating them with respect, and establishing and maintaining good relationships with patients and colleagues (including those who are not doctors)
b. being competent in all areas of their practice
c. keeping knowledge and skills up to date
d. being trustworthy and acting with integrity and within the law
e. taking part in regular reviews of their own work and that of their team and taking steps to address any problems.'

6. Mr Jackson stated that the focus of the GMC's submissions is threefold; a. the seriousness of the identified failures represented by the proved Heads of Charge, b. the issue of Insight and c. the possibility of remediation and the future in terms of patient safety. He submitted that when the Tribunal is considering the issue of sanction a key issue it will have in mind is the scale, duration and seriousness of the doctor's proven conduct; and thus, how far the doctor has fallen below the required standard and relied on the Tribunal's findings in its Impairment Determination at paragraphs 21 to 23. He reminded the Tribunal that it found that Dr Peter's conduct was 'deplorable'.

7. Mr Jackson submitted that, in view of all the Tribunal's finding of current impairment, it must now reach its own independent judgement as to appropriate sanction to impose in this case which is a matter solely for the Tribunal. He submitted that, when considering all the available sanctions, that an order for erasure is the minimum sanction required in order to meet the needs of the over-arching objective.

8. Mr Jackson submitted that Dr Peters' submits that the doctor's sustained pattern of

serious misconduct, combined with the evidence pattern of avoidance of regulation, gives rise to real risk of repetition in the future, with the consequent serious risks to patient safety, the patients were vulnerable, as identified by the GMC expert, Dr E. He further submitted that, in the light of Dr Peters' complete lack of insight, the complete lack of remediation, and his overt efforts to avoid regulation, there remains a serious and obvious risk of repeated serious misconduct in the future.

9. Mr Jackson submitted that in all the circumstances, the only appropriate sanction should be one of erasure.

The Tribunal's Determination on Sanction

10. The Tribunal has borne in mind that the decision as to the appropriate sanction to impose, if any, is a matter for the Tribunal exercising its own judgement.

11. In reaching its decision, the Tribunal considered the over-arching objective of protecting the public and in particular the pursuit of (a) protecting, promoting and maintaining the health, safety and well-being of the public; (b) promoting and maintaining public confidence in the medical profession; and (c) promoting and maintaining proper professional standards and conduct for members of the medical profession. It reminded itself that it should start with the least restrictive sanction. It had regard to the principle of proportionality, weighing Dr Peters' interests with those of the public. It also reminded itself that though the Tribunal should make sure its sanction is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor. The Tribunal should have regard to the principle of proportionality weighing the interests of the public against those of Dr Peters. Once the Tribunal has determined that a certain sanction is necessary to protect the public and is therefore the minimum action required to do so then that sanction must be imposed even though this may lead to difficulties for Dr Peters. This is necessary to fulfil the overarching objective. The Tribunal reminded itself that the sanction must be consistent with the findings made.

12. In reaching its decision, the Tribunal has taken account of the SG and Good Medical Practice. The SG gives the Tribunal an authoritative steer and if the Tribunal departs from the steer of the SG it should give clear and case-specific reasons for doing so. The Tribunal reminded itself that the SG is a guide to decision-making and not a tariff that prescribes the sanction to be imposed. The Tribunal has a wide discretion and its decision on sanction involves a multi-factorial judgement. The Tribunal has taken account of all evidence provided and submissions made by Mr Jackson on behalf of the GMC.

13. The Tribunal took account of paragraphs 17 and 19 of the SG, which state:

> *'17. Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession (see paragraph 65 of Good medical practice). Although the tribunal should*

make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.

19. Good medical practice is the benchmark that doctors are expected to meet subject to any mitigating or aggravating factors. Action is taken where a serious or persistent breach of the guidance has put patient safety at risk or undermined public confidence in doctors.'

Aggravating and Mitigating Factors

14. The Tribunal has already set out its decision on the facts and impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Dr Peters' registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case. It took account of paragraphs 24 to 26 of the SG, which state:

'24 The tribunal needs to consider and balance any mitigating factors presented by the doctor against the central aim of sanctions (see paragraphs 14–16). The tribunal is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession.

25. The following are examples of mitigating factors.

a. Evidence that the doctor understands the problem and has insight, and of their attempts to address or remediate it. This could include the doctor admitting facts relating to the case, apologising to the patient (see paragraphs 42–44), making efforts to prevent behaviour recurring, or correcting deficiencies in performance or knowledge of English.

b. Evidence that the doctor is adhering to important principles of good practice (ie keeping up to date, working within their area of competence), and of the doctor's character and previous history. This could include evidence that the doctor has not previously been found to have impaired fitness to practise by a tribunal, a previous MPTS panel or by the GMC's previous panels or committees.

c. Circumstances leading up to any incidents that raise concern – eg inexperience (see paragraphs 27–30) or a lack of training and supervision at work.

d. Personal and professional matters, such as work-related stress.

e. Lapse of time since an incident occurred.

26. If the doctor is presenting evidence that they have attempted to address or remediate the problem, the tribunal should be aware that Good medical practice states that doctors should do the following (this list is not exhaustive):

a. Raise concerns if patients are at risk because of inadequate premises, equipment or other resources, policies or systems, and put matters right where possible (Good medical practice, paragraph 25b).

b. Ask for advice from a colleague, defence body or the GMC if they are concerned that a colleague may not be fit to practise and may be putting patients at risk. If they remain concerned, they must report this in line with GMC guidance and any relevant workplace policy, making a note of steps taken (Good medical practice, paragraph 25c).

c. Be open and honest with patients if things go wrong and respond promptly, fully and honestly to complaints and apologise where appropriate. They must not allow a patient's complaint to adversely affect the care or treatment they provide or arrange (Good medical practice, paragraphs 55 and 61).

d. Cooperate with formal inquiries into the treatment of a patient and complaints procedures, disclosing information relevant to an investigation to anyone entitled to it (Good medical practice, paragraphs 72–74).

e Keep their knowledge and skills up to date and work with colleagues and patients to improve the quality of their work and promote patient safety (Good medical practice, paragraphs 8–13 and 22–23).

f Have the necessary knowledge of English to provide a good standard of practice and care (Good medical practice, paragraph 14.1).'

15. The Tribunal also had regard to the following paragraphs in the SG:

'32. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this.

33. In such serious cases, the tribunal must fully and clearly explain:

a. the extent to which the issues can be remediated

b. the steps the doctor has taken

c. how the seriousness of the findings – including the doctor's failure to take steps earlier – justifies the tribunal taking action, notwithstanding the steps subsequently taken.

39. When considering whether any references or testimonials are relevant to its decision, the tribunal should also consider: a whether the testimonial is relevant to the specific findings the tribunal has made about the doctor b the extent to which the views expressed in the testimonial are supported by other available evidence c how long the author has known the doctor d how recently the author has had experience of the doctor's behaviour or work e the relationship between the author and the doctor (eg senior colleague) f whether there is any evidence that the author has a conflict of interest in providing the testimonial.

40. As with other mitigating factors, any references or testimonials will also need to be weighed appropriately against the nature of the facts found proved.

16. It also had regard to the following paragraphs of the SG in relation to insight:

'46. A doctor is likely to have insight if they: a accept they should have behaved differently (showing empathy and understanding) b take timely steps to remediate (see paragraphs 31–33) and apologise at an early stage11 before the hearing c demonstrate the timely development of insight during the investigation and hearing.

51. It is important for tribunals to consider insight, or lack of, when determining sanctions. It is particularly important in cases where the doctor and the GMC agree undertakings or the tribunal imposes conditions. The tribunal must be assured that this approach adequately protects patients, in that the doctor has recognised the steps they need to take to limit their practice to remediate.

52. A doctor is likely to lack insight if they: a refuse to apologise or accept their mistakes b promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing c do not demonstrate the timely development of insight'.

17. The Tribunal considered the SG guidance about vulnerable patients:

'145. Where a patient is particularly vulnerable, there is an even greater duty on the doctor to safeguard the patient. Some patients are likely to be more vulnerable than others because of certain characteristics or circumstances, such as: (a) presence of mental health issues (b) not applicable; (c) disability or frailty (d) not applicable; (e) history of abuse or neglect.'

Aggravating Factors

18. The Tribunal considered the aggravating factors (a - l) in this case are:

a. Dr Peters' misconduct involved persistent and serious failures to follow GMP, GPPMMD and in the cases of Patients Q and R HLPGPRGP.

b. In prescribing Mimpara and Celsentri Dr Peters was acting outside his area of competence and expertise.

c. Patients A to R were all vulnerable because of apparent diagnoses of mental health problems.

d. There were risks of serious mental and physical harm and death to Patients A to R as a result of their circumstances and the combination of drugs prescribed by Dr Peters.

e. In its impairment judgement the Tribunal agreed with Dr E's conclusions in all four of his reports that Dr Peters' performance fell seriously below the standard expected of a staff grade psychiatrist and that '*Dr Peters amply evidences that he completely misses the salient point when prescribing Mimpara and Celsentri'.*

f. In its impairment judgement the Tribunal was of the opinion Dr Peters' actions would be considered deplorable by members of the medical profession.

g. While Dr Peters accepted he made mistakes and has promised not to issue private prescriptions again he also expressed no regret for his actions. His responses are set out in the Tribunal's determination as to impairment. The Tribunal noted in particular the following comments made by Dr Peters referred to in its impairment determination:

> *'I just want to write to you and your team that my action in writing the prescription for these two gentlemen was done in good faith to help them because it was at the peak of the pandemic and I assumed their diagnosis to be genuine…*
>
> *My actions in writing those 2 prescriptions was totally in good faith to help someone at their own time of need…*
>
> *…that all I was doing is providing repeat prescription for persons on holiday or passing through the UK who required medications at this time to keep them well and who if not given these medications may suffer deterioration in their physical health or suffer mental breakdown. He also did not factor in that I was only writing a repeat prescription; copying prescriptions that were written by a UK based consultant physician...*
>
> *…I can only reiterate the fact that the prescriptions I wrote were repeat prescriptions based on existing prescription that has been written by another doctor whom I was told is no longer in practice. They were not prescriptions I initiated rather; they were repeats to ensure that the chain of compliance was not broken…*
>
> *I as a person, do have a caring heart and loves to help whenever I am able. I have come to the end of my career, and I have no regrets for helping these my people.' I have had a good life, like I said , I have no regrets and if I am given the chance, I*

will still love to help my fellow human being with my knowledge and skill. I do not feel there is anything wrong in helping someone else…

…The truth in my case investigation is that NO ONE,. NOT EVEN ONE OF THE MEMBER OF THE PUBLIC WAS HARMED BY MY PRESCRIPTION. I have not willingly gone out to put the public health in danger for a single day in my 29 years of practice in this country. And coincidentally all the people I wrote private prescription for are having a good time in Egypt...'

h. In its impairment judgement the Tribunal agreed with Dr E that Dr Peters lacked insight. Dr E stated at paragraph 22 of his 14 October 2022 report of Dr Peters comments '*All the medications were not stimulants or Psychedelic in any shape or form*' and '*All the medications are not addictive and as such were not sold or bought from the black market 'Dr Peters amply evidences that he completely misses the salient point, which is that he prescribed specialist medications outside his expertise (Mimpara and Celsentri), which may be life threatening to patients if not properly prescribed and monitored by specialists, and that he failed to follow GMC guidance in terms of accessing information regarding Patients A-R's mental and physical health status, and failed to arrange follow up monitoring of same.'*

i. Dr Peters failure to work collaboratively or attempt to do so. Dr Peters provided no evidence that he (a) attempted to contact any of the medical professionals treating Patients A to R (e.g. by asking each patient for names and contact details), (b) attempted to contact Dr S who had issued the original prescriptions; and (c) attempted to contact any colleagues with expertise in HIV or hyperparathyroidism.

j. Dr Peters in issuing private prescriptions while not a GP and without any evidence of working collaboratively acted without governance or audit.

k. Dr Peters failed to raise any concerns with Patients A to R or with colleagues or with departments with expertise in HIV and/or hyperparathyroidism or with regulatory authorities about the requests to issue private prescriptions taking into account his lack of expertise and competence and the complexities of the conditions and medications he was dealing with.

l. Dr Peters' lack of indemnity insurance meant that if anything went wrong the patients had no ready means of redress.

Mitigating Factors

19. The Tribunal found that the potential mitigating features listed in paragraphs 24-26 of the SG are not present in this case save for (a) Dr Peters' good character; (b) the testimonials; (c) the lapse of time since the prescriptions were issued with no subsequent issue of prescriptions; and (d) his offer to undertake remediating work. The Tribunal gave little weight to the

testimonials since those providing them had scant understanding of the allegations against Dr Peters. The Tribunal noted the following expressions of regret by Dr Peters:

> *'…..and I assumed their diagnosis to be genuine which looking back was a big mistake which looking back caused me to step out of line with the gmc guidelines that I hold and respect dearly. I promise never to step out of line in this manner. I just wish to be given another chance to carry on in rendering services to humanity as I have been doing all these years.*
>
> *I make an undertaking to attend any relevant courses, seminars, workshops and read material that promote /teach safe prescribing and I state categorically that I have abided by the directive, not to do any further private prescription since April 2020'*

20. The Tribunal considered the aggravating factors, taken together, made Dr Peters' misconduct more serious and pointed to towards a more restrictive sanction.

No action

21. The Tribunal first considered whether to conclude Dr Peters' case by taking no further action with regard to his registration. The Tribunal had regard to para 70 SG which sets out that exceptional circumstances are unusual, special or uncommon and cases in which this applied were likely to be very rare. The Tribunal determined that Dr Peters' fitness to practise is impaired by reason of his misconduct and considered that there are no exceptional circumstances in this case where taking no action would be appropriate.

Undertakings

22. Undertakings must be agreed by the GMC and the practitioner. The Tribunal must be satisfied that the undertakings sufficient to protect patients and the public interest. Para 74 SG advises that undertakings are likely to be workable where: (a) the doctor has insight that they need to restrict their practice; (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 that the doctor will comply with them; and (d) the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised. The Tribunal finds that this sanction is not available since there is no agreement whereby the Tribunal can consider undertakings and Dr Peters is not present to enter into any undertakings.

Conditions

23. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Peters' registration. It has borne in mind that any conditions imposed would need to be appropriate, proportionate, workable and measurable. It reminded itself of the SG guidance on when 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

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.

84. Depending on the type of case (eg health, language, performance or misconduct), some or all of the following factors being present (this list is not exhaustive) would indicate that conditions may be appropriate:
a. no evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a
doctor's unwillingness to engage
b. identifiable areas of their practice are in need of assessment or retraining
c willing to respond positively to retraining, with evidence that they are committed to keeping their knowledge and skills up to date throughout their working life, improving the quality of their work and promoting
patient safety (Good medical practice, paragraphs 7–13 on knowledge, skills and performance and paragraphs 22–23 on safety and quality)
d. willing to be open and honest with patients if things go wrong (Good medical practice, paragraphs 55 and 61)
e. has insight into any health problems, complies with the guidance on health (Good medical practice, paragraphs 28–30) and will abide by conditions relating to their medical condition, treatment and supervision
and will not put patients in danger, either directly or indirectly, as a result of conditional registration.'

24. The Tribunal considered that the sanction of conditions in Dr Peters' case was not appropriate because of the following factors. Dr Peters' misconduct represented such a serious and persistent failure to follow basic guidelines that conditions were insufficient to address his failings, to ensure the safety of patients and to promote public confidence in the medical profession. The Tribunal found that Dr Peters lacks sufficient insight as set out in its determination on impairment. The Tribunal was not satisfied that retraining or a period of supervision would be successful. Dr Peters has not arranged or undertaken any courses or any form of remediation. Dr Peters applied unsuccessfully for voluntary erasure. He has retired from clinical practice. He has not engaged with these proceedings. Despite a promise that he would do whatever course necessary he has not arranged any form of remediation. In light of these factors the Tribunal was not satisfied that Dr Peters would be willing to respond positively to retraining. There is no evidence that Dr Peters is committed to improving the quality of his work

or keeping his knowledge up to date or that he recognises what he could do to promote patient safety. There is no evidence that Dr Peters would be open with patients about the limits of his competence and his safe prescribing of medication for complex conditions. Given Dr Peters' lack of engagement with these proceedings the Tribunal is not satisfied that he would comply with conditions.

Suspension

25. The Tribunal went on to consider whether to impose a period of suspension on Dr Peters' registration. The Tribunal noted that suspension has a deterrent effect and could be used to send a signal to Dr Peters, the profession, and the public about what is regarded as behaviour unbefitting a registered doctor. The Tribunal was mindful that the SG provides that suspension may be appropriate where there is an acknowledgement of fault, and it is satisfied the conduct will not be repeated.

26. The Tribunal had regard to the paragraphs of the SG which state:

> *'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.*
>
> *94. Suspension is also likely to be appropriate in a case of deficient performance… in which the doctor currently poses a risk of harm to patients but where there is evidence that they have gained insight into the deficiencies and have the potential to remediate if prepared to undergo a rehabilitation or retraining programme.*
>
> *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…*

b. In cases involving deficient performance where there is a risk to patient safety if the doctor's registration is not suspended and where the doctor demonstrates potential for remediation or retraining.

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.'

27. The Tribunal determined that the sanction of suspension was not appropriate because of the following factors. Dr Peters' misconduct was so serious that in the Tribunal's judgement it is fundamentally incompatible with continued registration. The Tribunal is of this view because whilst his misconduct was capable of remediation, it was not satisfied that Dr Peters has sufficiently acknowledged fault. He has displayed a cavalier attitude to basic guidance and procedures and taken no steps to remediate.

28. The Tribunal was not satisfied that his misconduct is unlikely to be repeated. Dr Peters has provided no evidence that he has mitigated his misconduct. The Tribunal found insufficient evidence that Dr Peters has gained insight into the deficiencies and there is insufficient evidence that he has the potential to remediate and is prepared to undergo a rehabilitation or retraining programme. The Tribunal was not satisfied that Dr Peters has insight nor that he does not pose a significant risk of repeating behaviour. Dr Peters has not arranged or undertaken any courses or any form of remediation. Dr Peters applied unsuccessfully for voluntary erasure. He has retired from practice. He has not engaged with these proceedings. Despite a promise that he would do whatever course necessary he has not arranged any form of remediation.

29. The Tribunal was concerned that Dr Peters' repeated and sustained errors of judgement that led to his misconduct would be very difficult to remediate in the circumstances of this case where he had practised so far outside the limits of his own competency and experience.

30. In terms of Dr Peters' own capacity to remediate for his misconduct, the Tribunal was of the view that this was primarily dependent on his engagement. The Tribunal considered that if Dr Peters had engaged, he may have had the potential to respond positively to re-training. However, the Tribunal noted that Dr Peters had applied unsuccessfully for voluntary erasure and now retired from his NHS clinical practice. The Tribunal could not be satisfied that Dr Peters would, or could, engage in appropriate training to remediate his misconduct.

31. The Tribunal found that it could not be satisfied that Dr Peters would successfully remediate his misconduct. In view of his limited insight set out in his written submission, and there being no evidence of any remediation, the Tribunal determined that there remained an

ongoing risk of repetition arising from Dr Peters' failings in judgement and decision-making and his apparent disregard for the guidance in place to protect patients.

32. The Tribunal considered whether a period of suspension would be sufficiently restrictive to promote and maintain public confidence in the medical profession and standards of conduct for the profession. The Tribunal has already decided that Dr Peters' actions had brought the profession into disrepute and that there was an ongoing risk that he could do so again in the future. The Tribunal considered that a patient consulting a doctor has a right to expect that their doctor has the relevant knowledge and experience to treat them safely, that their doctor follows the relevant guidance, which is in place to protect them and ensure that they will not be harmed. This was not the case for the patients A to R. Patients and the public need to be confident that they are protected by appropriate regulation.

33. Taking all of the above into account, the Tribunal determined that Dr Peters misconduct breached the trust that the patients were entitled to have in a doctor, to such an extent that his actions were fundamentally incompatible with continued registration. The Tribunal was of the view that the sanction of suspension would not meet the overarching objective to protect the public and would not be sufficient to maintain public confidence in the profession nor would suspension be sufficient to maintain standards and promote good medical practice in the profession. Accordingly, the Tribunal determined that suspending Dr Peters' registration would not be appropriate or proportionate to mark the seriousness of his misconduct.

Erasure

34. The Tribunal went on to consider the sanction of erasure. The Tribunal reminded itself of the aggravating factors it had identified in this case and noted the following paragraphs of the SG were relevant to its deliberations.

> *'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.*
> >
> > *c. Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients*

(see further guidance below at paragraphs 129–132 regarding failure to provide an acceptable level of treatment or care).

d. Abuse of position/trust (see Good medical practice, paragraph 65: 'You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession').

e. Violation of a patient's rights/exploiting vulnerable people (see Good medical practice, paragraph 27 on children and young people,
paragraph 54 regarding expressing personal beliefs and paragraph 70 regarding information about services).

f. Offences of a sexual nature, including involvement in child sex abuse materials (see further guidance below at paragraphs
151 - 159).'

35. The Tribunal also had regard to paragraphs 129, 130 and 132 of the SG, relating to cases where a doctor's misconduct arises from an unacceptable level of treatment or care:

'129. Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards (set out in domains one and four of Good medical practice on knowledge, skills and performance, and maintaining trust). Particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to 'Make the care of [your] patients [your] first concern' (Good medical practice, paragraph 1).

130. A particularly important consideration in these cases is whether a doctor has developed, or has the potential to develop, insight into these failures. Where insight is not evident, it is likely that conditions on registration or suspension may not be appropriate or sufficient.

132. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients and should have taken steps earlier to prevent this.'

36. The Tribunal took account of paragraph 136 which states:

'136. Doctors are expected to work collaboratively with colleagues to maintain or improve patient care. These duties are set out in paragraphs 35–37 of Good medical practice.'

37. The Tribunal determined that Dr Peters' conduct represented a particularly serious departure from Good Medical Practice and GPPMMD and in the cases of Patients Q and R

HLPGPRGP where his behaviour is fundamentally incompatible with being a doctor. The Tribunal was also satisfied that Dr Peters' misconduct amounted to a reckless disregard for the principles set out in GMP and GPPMMD and in the cases of Patients Q and R HLPGPRGP. The Tribunal was also satisfied that Dr Peters' misconduct risked serious mental and/or physical harm or death to his patients given the nature of the patients, their complex conditions and the combination and amounts of drugs prescribed. The Tribunal is satisfied that given the lack of sufficient insight and lack of remediation there is a continuing risk to patients from Dr Peters. The Tribunal is also satisfied that Dr Peter's misconduct amounted to a serious abuse of his position of trust and the public's trust in the profession. Dr Peters failed to make sure that his conduct justified his patients' trust and the public's trust in the profession. The Tribunal is also satisfied that Dr Peters has demonstrated a persistent lack of insight into the seriousness of his actions and the consequences. The Tribunal is satisfied that Dr Peters' actions fell seriously below that expected of a staff grade psychiatrist which amounted to a reckless disregard to patient safety and was a breach of the fundamental duty of doctors to make the care of his patients his first concern. The Tribunal is not satisfied that Dr Peters has developed or has the potential to develop insight into his failings. As set out above it is not satisfied that conditions or suspension are appropriate or sufficient. The Tribunal finds that Dr Peters' misconduct is capable of remediation but that there is no realistic prospect of remediation because (a) Dr Peters while saying he would co-operate with remediation, has taken no active steps to do so; (b) Has not engaged with these proceedings, in particular to provide the Tribunal with more expansive or consistent information about his future intentions; and (c) Applied unsuccessfully to voluntarily erase himself. These factors persuade the Tribunal that Dr Peters lacks the insight or commitment to remediate making his failings irremediable in the circumstances of this case. The Tribunal has determined that erasure was the only sanction sufficient to mark the seriousness of such misconduct, to protect patients, promote and maintain public confidence in the profession and standards of conduct for the profession.

38. The Tribunal therefore determined that Dr Peters' name should be erased from the Medical Register.

Determination on Immediate Order - 26/10/2022

1. Having determined that Dr Peters' name be erased from the Medical Register, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether his registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Mr Jackson J submitted that an immediate order of suspension is necessary for the protection of members of the public and in the public interest. He referred the Tribunal to paragraphs 172, 173 and 178 of the SG, in which state:

> *'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. The interests of the doctor include avoiding putting them in a*

position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.

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.'

3. Mr Jackson submitted that the consequences of not imposing an immediate order is that, should Dr Peters decide to appeal, the substantive order of erasure is suspended. He stated that Dr Peters has no reason for an immediate order not to be imposed as he has now retired from his NHS practice and has no ongoing obligations to patients.

4. Mr Jackson submitted that in the interest of public safety the Tribunal should have regard to its determination on sanction with respect to Dr Peters prescribing outside his area of expertise. He also reminded the Tribunal that it found Dr Peters lacked insight and submitted that it would be anomalous not to impose an immediate order, as it concluded that Dr Peters presents a current and future risk to patients. Mr Jackson submitted that the interim order should be revoked.

The Tribunal's Determination

5. The Tribunal has taken account of Mr Jackson's submissions and paragraphs 172 and 173 of the SG.

6. In light of the seriousness of Dr Peters' misconduct, its findings on impairment, and the sanction it has imposed, the Tribunal was of the view that he may pose a risk to patient safety if permitted to practise without restriction or may not comply with and any conditions imposed. It highlighted the aggravating features in its impairment and sanction judgement. It highlighted the lack of insight, lack of remorse, and expressions from Dr Peters that he would do the same again, and that he considered he was doing the right thing. It noted that Dr Peters could be put under pressure by the same or future patients to issue private prescriptions as he had for Patients A to R. It noted that whilst Dr Peters has retired from his NHS practice and sought voluntary erasure, the Tribunal could not be satisfied that he would not practise privately. The Tribunal also noted that given that Dr Peters had retired from his NHS work, an immediate order was unlikely to impact patients. The Tribunal agreed with Mr Jackson's submission that it would appear anomalous not to make an

immediate order given the Tribunal's findings and determinations. It also considered that members of the public would be surprised if an immediate order was not made. Therefore, the Tribunal determined that an immediate order is necessary for the protection of the public and in the public interest to suspend Dr Peters' registration with immediate effect.

7. The interim order is hereby revoked.

8. This means that Dr Peters' registration will be suspended from the date on which notification of this decision is deemed to have been served upon him. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

9. The interim order currently imposed on Dr Peter's registration will be revoked when the immediate order takes effect.

10. That concludes the case.

ANNEX A – 17/10/2022

Application on Service and Proceeding in absence

1. Dr Peters is neither present nor legally represented at this hearing. The Tribunal has considered whether notice of this hearing has been properly served upon Dr Peters in accordance with Rules 20 and 40 of the General Medical Council (Fitness to Practise) Rules 2004 (as amended) (the Rules), and Schedule 4, Paragraph 8 of the Medical Act 1983 (as amended). In so doing, the Tribunal has taken into account all the information placed before it, together with Mr Simon Jackson KC, GMC Counsel's submissions on behalf of the General Medical Council (GMC).

2. The Tribunal was provided with a screenshot of Dr Peters' registered postal and email addresses.

3. The Tribunal noted the GMC's information letter containing details of the hearing was sent to Dr Peters by email on 16 September 2022, to which he replied on the same day. It also noted the further emails between the GMC and Dr Peters. It also noted that Dr Peters had participated in case management hearings including one on 7 October 2022 whereby he was aware of the hearing dates.

4. The Tribunal noted the Medical Practitioners Tribunal Service (MPTS) Notice of Hearing letter was sent to Dr Peters by emails dated 8 and 9 September 2022 to which he replied, confirming receipt on 10 September 2022.

5. Mr Jackson referred the Tribunal to the relevant documents in the service bundle and service addenda. He submitted that in light of the response from Dr Peters in his email dated 10 October 2022, confirming his non-attendance, the Tribunal can be satisfied that service has been effected.

6. The Tribunal was satisfied that service of the Notice of Hearing has been effected, in accordance with Rule 40.

Proceeding in Absence

7. Having been satisfied that the Notice of Hearing has been properly served, the Tribunal went on to consider whether to exercise its discretion under Rule 31 of the Rules to proceed with the hearing in Dr Peters' absence.

8. Mr Jackson referred to his written submissions on proceeding in Dr Peters absence which the Tribunal had read. Mr Jackson confirmed that Dr Peters has retired from clinical practice. In conclusion, Mr Jackson submitted Dr Peters has been properly served with the GMC's Notice of

hearing, in accordance with the Rules and the Medical Act 1983 and that these proceedings should now proceed in accordance with the principles of the 'over-arching objective'.

9. The Tribunal balanced Dr Peters' interests with the public interest in deciding whether to proceed in his absence. In doing so the Tribunal took account of Dr Peters' email to the GMC 10 October 2022 in which he stated '*…I will not be attending the MPTS trial next week…*'. In addition, Dr Peters was telephoned this morning by a member of the MPTS and he confirmed he was aware of the hearing and will not be attending.

10. In deciding whether to exercise its discretion the Tribunal bore in mind the factors set out in the case law and the submissions by Mr Jackson. The Tribunal was satisfied that it had a discretion to proceed in Dr Peters' absence, that a decision to proceed in the absence of Dr Peters had to be taken with great care and was exceptional, that it had to consider the factors set out in the decided cases, it had to apply the overarching objective of protecting the public and consider fairness to Dr Peters as of prime importance.

11. The Tribunal considered the potential disadvantage to Dr Peters in not attending the hearing but weighed that against the wider public interest. The Tribunal noted that Dr Peters has not requested an adjournment of today's hearing and considered that he has voluntarily absented himself from these proceedings. The Tribunal considered that there was a burden on Dr Peters to engage with the proceedings and that it would run counter to the overarching objective if a doctor could effectively frustrate the process and challenge any decision to proceed in absence when that doctor had deliberately failed to engage in the hearing.

12. The Tribunal decided that were it to adjourn today and reconvene at a later date, there is no indication that Dr Peters would attend a hearing in the future. There is a clear public interest in proceeding with the hearing today and nothing would be gained by postponing the hearing. The Tribunal could find no good reason not to proceed with the hearing.

13. On the basis of the information provided and in accordance with Rule 31, the Tribunal has determined that there is a clear public interest in proceeding with the review hearing in this case and it is appropriate to proceed in the absence of Dr Peters.

14. The Tribunal did not draw any adverse inference from Dr Peters' absence.

ANNEX B– 17/10/2022

Application to Amend the Allegation under Rule 17(6) and to adduce further evidence under Rule 34(1)

1. Mr Simon Jackson KC, made applications to amend the Allegation and to adduce further evidence under Rules 17(6) and (b) and 34(1) of the Fitness to Practice Rules 2004, as amended, which state:

'17(6) Where it appears to the Tribunal at any time that-

(a) the particulars of the allegation or the facts upon which it is based, of which notice has been given under rule 15, should be amended;
and
(b) the amendment can be made without injustice,

it may, after hearing the parties and consulting with the Legal Assessor, amend the particulars on appropriate terms.

34(1) The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.'

2. Mr Jackson submitted that the Rule 7 letter sent to Dr Peters included the GMC's draft particularised charges as the basis for the primary allegation of impairment of fitness to practice. He said that Dr Peters confirmed receipt of the Rule 7 letter in his two email responses. He stated that this is standard practice with the Rule 7 letters, however, submitted that it is under no formal obligation to provide this information, but the GMC did so as a matter of practice. He stated that the only requirement is to inform the doctor of the 'Allegation', as defined by Rule 2, and the facts or matters that appear to raise a concern relating to the Practitioner's fitness to practise which is a very general requirement. He stated that the initial Rule 7 Allegation is the basis for the Rule 15 letter first sent to the doctor.

3. In this regard Mr Jackson observed that it is important to note and underline, that the first time the GMC is actually required, by reference to the 2004 Rules, to 'particularise the allegation against the Practitioner and detail the facts upon which it is based' is only after the case has been referred to a Fitness to Practise Panel, by the Case Examiners under Rule 15. He stated that this approach is consistent with Parliament recognising that the finalised particulars of the allegations, and the full details of the facts that led to "allegation" may only be available when all information is available and fully analysed after the Case Examiners' referral, as was the case here.

4. Mr Jackson referred the Tribunal to the decision of the Court of Appeal in the case *GMC v R (Zia) [2011] EWCA Civ 743.* Lord Justice Jackson, at paragraph 35 observed:
'This argument chimes with the judge's view that the purpose of these provisions is to provide procedural protections for the doctor. I do not agree with this purposive approach to the interpretation of the Rules. It needs to be borne in mind that the statutory objective set out in the Medical Act 1983 is the protection, promotion and maintenance of the health and safety of the public. In my view, the purpose of the Rules is to achieve a balance. First and foremost, the function of the Rules is to protect, promote and maintain the health and safety of the public. Also it is the function of the Rules to provide proper protection of the doctor against whom accusations are made, some of which may well turn out to be unfounded. It can be seen that on any view the

majority of cases which are dealt with under the Rules will indeed receive consideration both from the registrar and subsequently from case examiners. However, as I read the Rules it is not invariably or inflexibly a case that whatever course may be taken matters will also be considered by case examiners before they proceed further.'

Lord Justice Tomlinson, at Paragraph 46 added:

'I agree. The judge was in my view side-tracked by his belief that the process described in the Rules is designed to protect the proper interests of a person (that is to say a doctor) against whom an allegation has been made. I have no doubt that the process is intended and designed to be fair, and it is axiomatic that in conducting the process the various persons invested with powers under the Rules are required to act fairly. However, the judge, in my view, approached the matter from the wrong starting point. The starting point is, as my Lord, Jackson LJ has pointed out, that pursuant to Section (1(a) of the Medical Act 1983 the main objective of the General Council in exercising its is to protect, promote and maintain the health and safety of the public. Thus I do not, for my part, approach the construction of the Rules on the basis that the various stages described therein should be regarded as prescribed for the protection of the person against whom the allegation is made. I approach the task of construction of the Rules rather on the footing that the Rules are intended to provide a framework for the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners.'
(Mr Jackson's underlining)

5. Mr Jackson also stated that the GMC also relies on the principles set out in the more recent decision in the case of *Louise Schodlok v General Medical Council [2012] EWHC 4038 Admin*, which deals with the amendment of charges between Rule 8 stage and the sending out of the Rule 15(2) Notice of hearing. He submitted that the proposed amendments arise through no fault of the GMC, and it is a response to the successive disclosure of the relevant patient records by Dr Peters to the GMC, the last of which was the 10 October 2022. Mr Jackson provided a chronology as follows:

- 22 October 2020: Dr Peters sent the GMC his notes for Patient Q and R
- 30 June 2022: Dr Peters sent Dr S' prescriptions for Patients Q and R, the day before a PHM on the 1 July 2022.
- 25 July 2022: Dr Peters sent the GMC Dr S' prescriptions for Patients A-P, as part of his defence disclosure
- 10 October 2022: Dr Peters sent the GMC new Dr S' prescriptions for Patients A-C, this following the second PHM on 07 October 2022.

6. Mr Jackson submitted that following the receipt of these last prescriptions, which followed the earlier need for service of a section 35A request (in October 2020), the only fair way of dealing with the new evidence was to seek the further views of the GMC's appointed expert. Dr E, to comment. He stated that Dr E's additional report was sent to Dr Peters. Mr Jackson stated that it is this sequence of events which have led to the need for amendment of the Rule 15 Letter.

7. Mr Jackson stated that all the new particulars arise of matters peculiarly within the knowledge of the doctor himself, and the allegation of acting outside his competence, a corner stone of Good Medical Practice was foreshadowed in the earlier expert reports that were provided to Dr Peters.

8. Mr Jackson submitted that the amended particulars of the Allegation are not of a fundamentally different nature such as to warrant a referral back to the Case Examiners, thereby delaying a hearing. He reminded the Tribunal that Dr Peters has indicated that he does not wish to participate in the hearing. He stated that the proposed amendments focus on clarifying the particulars of failure within the primary allegation, in terms of what is meant, for example in Paragraph 1, by the phrases 'first obtaining' and 'first assessing'. He said that the existing reference to monitoring of the Mimpara is also clarified, based on the expert evidence. He submitted that these proposed amendments both assist the doctor and the Tribunal in better understanding the GMC's case.

9. Mr Jackson stated that it is effective case management in both the public interest and Dr Peters' interest, in having these charges adjudicated upon by the Tribunal. He submitted that these charges, as amended, should be heard and resolved by the Tribunal during this hearing. Mr Jackson submitted that it is also in Dr Peters' best interest that these proceedings are brought to a conclusion sooner rather later, in accordance with the 'overarching objective' pursuant to sections 1A & 1B of the Medical Act 1983. He stated that the Rules allow, and case law permits amendments to be made where the Notice of Hearing (or now the Allegation) has already been served on the practitioner. He remined the Tribunal, in relation to amendment of particulars of the allegation is governed by Rule 17(6) of the 2004 Rules and this provision allows for the amendment '*of the particulars of the allegation'* even after a Notice of Hearing has been drafted.

10. Mr Jackson submitted that upon due consideration of the circumstances of the case, there is no injustice to Dr Peters in allowing the proposed amendments. He stated that the subject matter of the proposed amended charges is the same as the existing charges. They have the same basis, in terms of being related to a determination in an overseas jurisdiction.
He submitted that there is no prejudice to Dr Peters in allowing the GMC to proceed with the amended Allegation, and that he can still have a fair hearing in respect of all the charges he faces as part of the Allegation, even should he wish to participate at this late stage of the proceedings.

11. In relation to adducing more evidence under rule 34(1) Mr Jackson submitted that Dr Peters has not requested an adjournment to consider the application to amend the Allegation and to adduce more evidence. He submitted that Dr Peters has voluntarily absented himself and chosen not to engage in the proceedings.

12. In response to the question as to whether Dr Peters has confirmed receipt of the GMC's email sent at 16.47hrs on Friday 14 October 2022, Mr Jackson confirmed that there was no confirmation from the doctor.

13. At the Tribunal's request and email was sent today to Dr Peters with the following questions:

'1. Please confirm that you received the email from the GMC dated 14 October 2022 regarding applications by the GMC to amend the Allegation and to adduce further evidence.

2.Have you had sufficient time to consider the applications and/or to take legal advice, if appropriate?

3. Are you still content for the Tribunal to proceed in your absence?'

14. The Tribunal noted Dr Peters' response as follows:

'Dear esteemed tribunal members, thank you for making an effort to display fairness from the outset of this hearing. Towards the last 3 weeks before this hearing, my wife became concerned about XXX and we both agreed that I should abstain from attending the hearing XXX. I have all these past 35years post graduation helped people to be healthier and happy and I deserve to be given the same chance XXX.
The moment I put this in writing to Ms G, I felt a lot better that [sic]I have felt in many weeks, I slept well, and I checked my emails less often which is why I did not see G's last email until this morning.
Talking of this morning, the moment my phone rang when Ms F called, I XXX.
Now, after going through the email from Ms G, I saw a lot of amendments in red and black and blue letters. everything appears jumbled up and confusing. at a first glance, I note that there are so many alterations and for example, the last page concerning patient [R], they changed the dose of Celsentri from 300mg to 3000mg, [this in fact is not in the Allegation] this is totally unacceptable and confusing because the acceptable dose of Celsentri is 300mg and not 3000mg. A dose of 3000mg is 10 times above the normal dose and this gives room for the GMC to state that Dr Peters has put the public in danger by writing beyond and above the normal dose.

Answer to question number 2. I have had time to consider on the surface the application. I do not intend to take legal advice.

1. I wish the tribunal to carry on in my absence as I have faith in every member that they will apply wisdom of matured minds in their deliberations in all fairness.
2. I have written down what I would have said in person.

Let me wish you all a happy and swift deliberations with a favourable outcome. All the best.
Dr Peters'

The Tribunal's Decision

15. The Tribunal considered Mr Jackson's applications under Rules 17(6) and 34(1) and determined to grant both applications for the following reasons. The Tribunal determined that it must consider both applications were in accordance with the overriding objective. In relation to the Rule 17(3) application to amend the allegations the Tribunal bore in mind that it must be satisfied that the application can be made without injustice to Dr Peters. In relation to the admission of late evidence under Rule 34 the Tribunal considered what is fair and what is relevant. It considered the arguments against granting the applications are that the Rules require formal notice normally 28 days notice of both the nature of the allegations and also of the service of evidence. The Tribunal was concerned about fairness in relation to the late service of the application to amend and the application to adduce new evidence which occurred fairly late on Friday 14 October 2022.

16. The Tribunal considered the factors in favour of granting the application. It bore in mind that the overarching objective is to protect the public and was satisfied that both applications are aimed at achieving that objective. The Tribunal also took into account that Dr Peters has demonstrated a succession of failures to respond, or to respond fully, to the MPTS Case Management orders. The Tribunal noted the Case Management order made on the 20 December 2021, whereby Dr Peters should have provided all his evidence by the 6 June 2022. It also noted the order of 1 July 2022 when he should have provided all his evidence by the 25 July 2022 and the order of 7 October 2022 when he should have provided all his evidence by the 10 October 2022. The Tribunal noted that Dr Peters has failed to fully respond to each one of those Case Management orders in not providing everything that he was to rely on.

17. The Tribunal considered that the amendments represent no material change to the nature of the misconduct that Dr Peters is accused of. It also noted that Dr Peters responded to an email sent by the MPTS today. The Tribunal noted that in his email Dr Peters made no objections to the GMC's applications. It noted that Dr Peters referred to the proceedings affecting his health and an element of confusion to the amendments. The Tribunal noted that Dr Peters did not ask for an adjournment, nor did he not seek to advance a medical certificate but urged the Tribunal to proceed with the hearing. The Tribunal considered that the substance of Dr Peters' email was to proceed in his absence.

18. The Tribunal noted that Dr Peters was provided with a copy of GMC's expert witness, Dr E's additional report. The Tribunal considered that there was no unfairness to Dr Peters as he would have had the opportunity to question Dr E during his oral evidence, had he chosen to attend the hearing. The Tribunal also considered that Dr E could have given oral evidence along the lines of his most recent report of 14 October 2022 in response to the late replies from Dr Peters which Dr Peters would have been able to listen and respond to had he attended.

19. Accordingly, the Tribunal determined that the GMC's applications to amend the Allegation and to adduce new evidence could be granted without injustice to Dr Peters and that the admission of the late GMC evidence was both fair and relevant. For clarification, the amended Allegation is as follows:

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

Patients A-P

1. Between 6 August 2019 and 29 November 2019, you inappropriately prescribed medication to Patients A-P, as described in Schedule 1, in that:

a. before prescribing, you failed to assess the patient(s) at all;

Mimpara

b. in respect of Patients A-I, you prescribed Mimpara, and you:

i. did so outside the limits of your competence without conferring with the relevant specialists;

ii. failed to, before prescribing, establish the relevant patient's:

1. blood pressure;

2. pulse rate;

3. heart sounds;

4. most recent ECG test result;

5. most recent blood test result for:

i. serum calcium levels;

ii. parathyroid hormone levels;

iii. failed to arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1bii1-5 above;

Celsentri

c. you prescribed Celsentri and failed to:

i. obtain, before prescribing, a recent white cell count/viral load result for the patient;

ii. arrange for the prompt follow up monitoring of the patient's white cell count/viral load;

iii. have contact and guidance from specialist HIV services when prescribing Celsentri;

iv. check for drug interactions;

v. liaise with HIV services to ensure the patient had follow-up and monitoring;

Xeplion

d. you prescribed Xeplion and failed to:

i. establish, before prescribing, the relevant patient's:

1. blood pressure;

2. pulse rate;

3. heart sounds;

4. height;

5. weight;

6. ECG;

ii. arrange for prompt follow up monitoring of one or more of the clinical indicators set out at paragraph 1di;

iii. ascertain the mental state of the patient before prescribing;

iv. check for drug interactions;

v. review the patient's recent metabolic status;

vi. record any handover to the patient's usual treating clinician(s);

e. you prescribed Celsentri and Xeplion together, without arranging for the monitoring of any side effects.

2. Your record keeping was inadequate in that:

a. (in the alternative to paragraph 1bii-1biii) when prescribing Mimpara to Patients A-I, as described in Schedule 1, you failed to record having undertaken the actions referred to in paragraph 1bii-1biii;

b. when prescribing to Patients A-P as described in Schedule 1, you failed to record:

i. (in the alternative to paragraph 1a) an adequate assessment of the patient;

ii. (in the alternative to paragraph 1c-e) having adequately undertaken the actions referred to in paragraph 1c-e;

c. in respect of Patient I, you failed to document your reasons for initiating treatment with Mimpara.

Patient Q

3. On or around 2 April 2020 you consulted with Patient Q and you inappropriately prescribed the medication described in Schedule 2 in that:

a. before prescribing you failed to:

i. verify Patient Q's identity;

ii. obtain consent to:

1. access Patient Q's medical records;

2. treat Patient Q;

iii. take an adequate history, in that you did not make an appropriate enquiry about Patient Q's:

1. presenting complaint;

2. psychiatric history;

3. medical history;

4. background history;

5. timing of depot medication to determine whether Patient Q had relapsed with medication in their system;

6. previous blood transfusion;

7. possible use of:

i. alternative remedies;

ii. alcohol;

iii. illegal substances;

iv. other medications obtained online;

iv. conduct an adequate risk assessment of Patient Q;

v. assess:

1. whether Patient Q was vulnerable;

2. Patient Q's capacity to consent;

vi. contact the following professionals involved in Patient Q's care in the patient's country of residence to verify the patient's clinical history:

1. GP;

2. mental health specialist;

3. HIV specialists;

vii. discuss alternative treatment options with Patient Q;

viii. tell Patient Q:

1. that it would be unsafe to prescribe without first receiving corroborative information about treatment and follow up in Patient Q's own country of residence;

2. whether your licence to practice and prescribe within Egypt was valid;

b. you failed to:

i. liaise with HIV services to ensure Patient Q had follow-up and monitoring;

ii. record:

1. (in the alternative to paragraphs 3a and 3bi) having undertaken the actions described at paragraphs 3a and 3bi;

2. Patient Q's mental state examination;

3. where the referral for Patient Q originated;

4. your rationale for accepting Patient Q's referral;

5. your reasons for prescribing the medication set out in Schedule 2.

<u>Patient R</u>

4. On or around 3 April 2020 you consulted with Patient R and you inappropriately prescribed the medication described in Schedule 3 in that:

a. before prescribing you failed to:

i. verify Patient R's identity;

ii. obtain consent to:

1. access Patient R's medical records;

2. treat Patient R;

iii. take an adequate history, in that you did not make an appropriate enquiry about Patient R's:

1. presenting complaint;

2. psychiatric history;

3. medical history;

4. background history;

5. timing of depot medication to determine whether Patient R had relapsed with medication in their system;

6. possible use of:

i. alternative remedies;

ii. alcohol;

iii. illegal substances;

iv. other medications obtained online;

iv. conduct an adequate risk assessment of Patient R;

v. assess:

1. whether Patient R was vulnerable;

2. Patient R's capacity to consent;

vi. contact the following professionals involved in Patient R's care in the patient's country of residence to verify the clinical history:

1. GP;

2. mental health specialist;

3. HIV specialists;

vii. discuss alternative treatment options with Patient R;

viii. tell Patient R:

1. that it would be unsafe to prescribe without first receiving corroborative information about treatment, and follow up in Patient R's own country of residence;

2. whether your licence to practise and prescribe within Egypt was valid;

b. you failed to:

i. liaise with HIV services to ensure Patient R had follow-up and monitoring;

ii. record:

1. (in the alternative to paragraphs 4a and 4bi) having undertaken the actions described at paragraphs 4a and 4bi;

2. Patient R's mental state examination;

3. where the referral for Patient R originated;

4. your rationale for accepting Patient R's referral;

5. your reasons for prescribing the medication set out in Schedule 3.

<u>All patients</u>

5. When prescribing Celsentri to Patients A-R as described in Schedules 1-3, you did so outside the limits of your competence.

6. Before you prescribed for Patients A-R as described in Schedules 1-3, you failed to:

a. take reasonable steps to contact the clinician who had previously prescribed to Patients A-R, Dr S, in order to ascertain whether the medication you were prescribing was necessary and appropriate;

b. check the Care and Quality Commission status of Dr S's clinical practice;

c. ensure that you had the appropriate:

i. registration for prescribing to patients in Egypt;

ii. adequate indemnity insurance to do so.

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

Schedule 1

XXX

Schedule 2

XXX

Schedule 3

XXX