**Record of Determinations – Medical Practitioners Tribunal**

**PUBLIC RECORD**

**Dates:** 24/06/2019 - 18/07/2019

**Medical Practitioner’s name:** Dr Dharson DHARMASENA

**GMC reference number:** 6106364

**Primary medical qualification:** MB BS 2004 University of London

**Type of case**
New - Misconduct

**Outcome on impairment**
Impaired

**Summary of outcome**
Suspension, 6 months.
Review hearing directed
Immediate order imposed

**Tribunal:**

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<th>Lay Tribunal Member (Chair)</th>
<th>Mr Sean Ell</th>
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<td>Lay Tribunal Member:</td>
<td>Mrs Michele Clare</td>
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<td>Medical Tribunal Member:</td>
<td>Dr Priya Iyer</td>
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<th>Legal Assessor:</th>
<th>Mr Rob Ward</th>
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<td></td>
<td>(24/06/2019 - 26/06/2019 and 01/07/2019 - 18/07/2019)</td>
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<td></td>
<td>Mrs Julia Oakford</td>
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<th>Miss Emma Saunders</th>
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<td>Ms Rosanna Sheerin</td>
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<td>(05/07/2019 PM)</td>
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<td>Ms Esther Morton</td>
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**Attendance and Representation:**

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| Medical Practitioner’s Representative: | Mr Bruce Henry, Counsel, instructed by BMA Law (24/06/2019 AM)  
Mr Simon Connolly, Counsel, instructed by BMA Law (26/06/2019 - 18/07/2019) |
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<tr>
<td>GMC Representative:</td>
<td>Mr Bob Sastry, Counsel</td>
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**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 Facts - 12/07/2019**

**Background**

1. Dr Dharmasena completed a BSc in Pharmacology in 2001 from The University of London and qualified with an MBBS from Guy’s, Kings & St Thomas’ school of medicine in 2004.

2. Prior to the events which are the subject of the hearing, Dr Dharmasena completed house officer jobs in medicine and surgery in Margate and Hastings respectively, before undertaking a number of surgical based jobs in the East Kent and Sussex areas. Dr Dharmasena completed a number of standalone and training approved jobs in a number of areas, including Accident and Emergency, before embarking on the General Practitioner (GP) training scheme 2008 to 2011. Dr Dharmasena worked in a number of locum GP posts before working as a full time salaried GP in East Kent in 2012, then full time partner at the St Richards Road Surgery in Deal from 2013 to 2015. He worked for his local Out of Hours service from 2011 to 2016 and then took a period of time away from medicine.

3. At the time of the events in question, Dr Dharmasena was practising as an online GP for White Pharmacy, an online private healthcare company, which he joined on 20 February 2017. He became the Clinical Director of White Pharmacy on 22 May 2017. Dr Dharmasena took a period of time away from medicine after leaving White Pharmacy in August 2017 before resuming locum GP work at The Limes Medical Centre from
January to July 2018 and worked for the Acute Response Team from November 2017 to date.

4. The Allegation that has led to Dr Dharmasena’s hearing relates to allegations by the General Medical Council (GMC) that Dr Dharmasena inappropriately prescribed opioid medications to patients from an online service, White Pharmacy. It is alleged that Dr Dharmasena failed to obtain an adequate medical history or to adequately assess Patients A to M. Dr Dharmasena did not have access to the patients’ GP records, instead referring to an online questionnaire that was completed by each patient when they placed their order.

5. Patients A to D and G to J refused to allow Dr Dharmasena to inform their GPs. It is alleged that Dr Dharmasena did not obtain an adequate medical history and did not assess the patients properly in circumstances where the medication prescribed had habit forming potential. This undermined any possible support needs of the patients pertaining to dependence on prescribed drugs. It is alleged that Dr Dharmasena prescribed the opioid medication without adequate and appropriate safeguarding, given the risk of dependency, and undermined possible support needs pertaining to opioid dependence.

6. On 25 May 2017 the Care Quality Commission (CQC) referred Dr Dharmasena to the GMC regarding the treatment provided to a number of patients. The GMC also received a number of complaint letters from GPs whose patients had been prescribed opioid medication by Dr Dharmasena via White Pharmacy.

The Outcome of Applications Made during the Facts Stage

7. The Tribunal refused Dr Dharmasena’s application, made pursuant to Rule 29(2) of the GMC (Fitness to Practise Rules) 2004 as amended (‘the Rules’), for the adjournment of the hearing. It also refused his application to sever the case from the joined case of Dr Pooley. The Tribunal’s full decision on the application is included at Annex A.

8. The Tribunal granted Dr Dharmasena’s application, made pursuant to Rule 29(2) of the Rules, for additional time, and adjourned the case for one day. The Tribunal’s full decision on the application is included at Annex B.

9. The Tribunal determined to amend the word ‘prescriptions’ to ‘prescription’ in paragraph 4 of the Allegation, in accordance with Rule 17(6) of the Rules. The schedule to the Allegation lists only one prescription and so the references in paragraph 4 of the Allegation to ‘prescriptions’ were incorrect. The Tribunal determined that the amendments could be made without injustice to either party. It was later identified that this was the same in respect of a number of other paragraphs of the Allegation, which the Tribunal also decided to amend. The amendments were therefore made in respect of Patients D to I and Patient M.
10. The Tribunal determined to add the value ‘100’ in relation to the three entries for Patient J, and amend the value ‘200’ to ‘100’ in relation to the two entries for Patient K, both in Schedule One to the Allegation, in accordance with Rule 17(6) of the Rules. The Tribunal determined that the amendments were factual corrections and could be made without injustice to either party.

11. The Tribunal determined, pursuant to Rule 34(13) and (14) of the Rules, that Dr O could give his evidence via telephone on 4 July 2019. Dr O had given evidence in person during the preceding four working days and this was a practical step to ensure that his evidence could be concluded in an appropriate timeframe.

12. The Tribunal granted the GMC’s application, made pursuant to Rule 17(6) of the Rules, for the amendment of the Allegation. This amendment was agreed by all parties. The amendment was to add the word ‘primarily’: “your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates”. This accurately reflected the information before the Tribunal and the amendment was made in respect of all of the patients, Patients A to M.

The Allegation and the Doctor’s Response

13. The Allegation made against Dr Dharmasena is as follows:

Patient A

1. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient A, in that:

   a. you failed to:

      i. obtain an adequate medical history, in that:

         aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

         Amended under Rule 17(6)
         To be determined

         bb. you failed to consult with Patient A;

         To be determined

         cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient A;
To be determined

dd. you took Patient A’s self-report at face value;
To be determined

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient A;
To be determined

cc. you failed to examine Patient A;
To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient A;
To be determined

ee. you took Patient A’s self-report at face value.
To be determined

iii. have an adequate knowledge of the patient’s health;
To be determined

iv. establish a clear diagnosis prior to initiating prescribing;
To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined

b. Patient A refused to allow you to inform their GP.
To be determined

c. you issued the prescriptions in the absence of the information listed at paragraph 1(a)(i)-(v) and despite the information at paragraph 1(b) when the medication prescribed had habit forming potential.
Admitted and found proved
d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient A to their own GP.

Admitted and found proved

e. in issuing the prescriptions in the absence of the information listed at paragraph 1(a)(i)- (v) your prescribing practice undermined any possible support needs of Patient A pertaining to dependence upon prescribed drugs.

Admitted and found proved

Patient B

2. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient B, in that:

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)

To be determined

bb. you failed to consult with Patient B;

To be determined

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient B;

Admitted and found proved

dd. you took Patient B’s self-report at face value;

To be determined

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient B;

To be determined

cc. you failed to examine Patient B;

To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient B;

Admitted and found proved

ee. you took Patient B’s self-report at face value.

To be determined

iii. have an adequate knowledge of the patient’s health;

To be determined

iv. establish a clear diagnosis prior to initiating prescribing;

To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.

To be determined

b. Patient B refused to allow you to inform their GP

To be determined

c. you issued the prescriptions in the absence of the information listed at paragraph 2(a)(i)–(v) and despite the information at paragraph 2(b) when the medication prescribed had habit forming potential.

To be determined

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient B to their own GP.

To be determined

e. in issuing the prescriptions in the absence of the information listed at paragraph 2(a)(i)–(v) your prescribing practice undermined any possible support needs of Patient B pertaining to dependence upon prescribed drugs.
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To be determined

Patient C

3. You inappropriately issued the online prescriptions at Schedule One ('the prescriptions') to Patient C, in that:

a. you failed to:

   i. obtain an adequate medical history, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      To be determined

      bb. you failed to consult with Patient C;
      To be determined

   cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient C;
      To be determined

   dd. you took Patient C's self-report at face value;
      To be determined

   ii. adequately assess the patient, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      To be determined

      bb. you failed to consult with Patient C;
      To be determined

      cc. you failed to examine Patient C;
      To be determined

      dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient C;
Admitted and found proved

ee. you took Patient C’s self-report at face value.
To be determined

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined

b. Patient C refused to allow you to inform their GP
To be determined

c. you issued the prescriptions in the absence of the information listed at paragraph 3(a)(i)- (v) and despite the information at paragraph 3(b) when the medication prescribed had habit forming potential.
Admitted and found proved

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient C to their own GP.
Admitted and found proved

e. in issuing the prescriptions in the absence of the information listed at paragraph 3(a)(i)- (v) your prescribing practice undermined any possible support needs of Patient C pertaining to dependence upon prescribed drugs.
Admitted and found proved

Patient D

4. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient D, in that:
Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:
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aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   \textbf{Amended under Rule 17(6)}
   \textbf{To be determined}

bb. you failed to consult with Patient D;
   \textbf{To be determined}

c. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient D;
   \textbf{Admitted and found proved}

dd. you took Patient D’s self-report at face value;
   \textbf{To be determined}

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   \textbf{Amended under Rule 17(6)}
   \textbf{To be determined}

bb. you failed to consult with Patient D;
   \textbf{To be determined}

c. you failed to examine Patient D;
   \textbf{To be determined}

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient D;
   \textbf{To be determined}

e. you took Patient D’s self-report at face value.
   \textbf{To be determined}

iii. have an adequate knowledge of the patient’s health;
    \textbf{To be determined}

iv. establish a clear diagnosis prior to initiating prescribing;
    \textbf{To be determined}
v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined

b. Patient D refused to allow you to inform their GP
To be determined

c. you issued the prescriptions prescription in the absence of the information listed at paragraph 4(a)(i)-(v) and despite the information at paragraph 4(b) when the medication prescribed had habit forming potential.
Amended under Rule 17(6)
Admitted and found proved

d. you issued the prescriptions prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient D to their own GP.
Amended under Rule 17(6)
Admitted and found proved

e. in issuing the prescriptions prescription in the absence of the information listed at paragraph 4(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient D pertaining to dependence upon prescribed drugs.
Amended under Rule 17(6)
Admitted and found proved

Patient E

5. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient E, in that:
Amended under Rule 17(6)

a. you failed to:
   i. obtain an adequate medical history, in that:
      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      To be determined
bb. you failed to consult with Patient E;
**To be determined**

c. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient E;
**To be determined**

d. you took Patient E’s self-report at face value;
**To be determined**

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
**Amended under Rule 17(6)**
**To be determined**

bb. you failed to consult with Patient E;
**To be determined**

cc. you failed to examine Patient E;
**To be determined**

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient E;
**To be determined**

ee. you took Patient E’s self-report at face value.
**To be determined**

iii. have an adequate knowledge of the patient’s health;
**To be determined**

iv. establish a clear diagnosis prior to initiating prescribing;
**To be determined**

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
**To be determined**
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b. you issued the prescription in the absence of the information listed at paragraph 5(a)(i)-(v) when the medication prescribed had habit forming potential.  
**Amended under Rule 17(6)**  
**To be determined**

c. you issued the prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient E to their own GP.  
**Amended under Rule 17(6)**  
**To be determined**

d. in issuing the prescription in the absence of the information listed at paragraph 5(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient E pertaining to dependence upon prescribed drugs.  
**Amended under Rule 17(6)**  
**To be determined**

e. you issued the prescription despite having reviewed Patient E’s care and recommending that opioid medication was not clinically indicated.  
**Amended under Rule 17(6)**  
**To be determined**

Patient F

6. You inappropriately issued the online prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient F, in that:  
**Amended under Rule 17(6)**

a. you failed to:

   i. obtain an adequate medical history, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;  
      **Amended under Rule 17(6)**  
      **To be determined**

      bb. you failed to consult with Patient F;  
      **To be determined**
cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient F;
   To be determined

dd. you took Patient F’s self-report at face value;
   To be determined

ii. adequately assess the patient, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      To be determined

   bb. you failed to consult with Patient F;
      To be determined

   cc. you failed to examine Patient F;
      To be determined

   dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient F;
      To be determined

   ee. you took Patient F’s self-report at face value.
      To be determined

iii. have an adequate knowledge of the patient’s health;
    To be determined

iv. establish a clear diagnosis prior to initiating prescribing;
    To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
   To be determined

b. you issued the prescription in the absence of the information listed at paragraph 6(a)(i)-(v) when the medication prescribed had habit forming potential.
   Amended under Rule 17(6)
   To be determined
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c. you issued the prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient F to their own GP.
**Amended under Rule 17(6)**
**To be determined**

d. in issuing the prescription in the absence of the information listed at paragraph 6(a)(i) - (v) your prescribing practice undermined any possible support needs of Patient F pertaining to dependence upon prescribed drugs.
**Amended under Rule 17(6)**
**To be determined**

e. you issued the prescription despite having reviewed Patient F’s care and recommending that long term use of opioid medication was not clinically indicated.
**Amended under Rule 17(6)**
**To be determined**

**Patient G**

7. You inappropriately issued the online prescription at Schedule One (‘the prescription’) to Patient G, in that:
**Amended under Rule 17(6)**

a. you failed to:
   i. obtain an adequate medical history, in that:
      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      **Amended under Rule 17(6)**
      **To be determined**
   
      bb. you failed to consult with Patient G;
      **To be determined**
   
      cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient G;
      **To be determined**
dd. you took Patient G’s self-report at face value;

To be determined

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)

To be determined

bb. you failed to consult with Patient G;

To be determined

cc. you failed to examine Patient G;

To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient G;

To be determined

ee. you took Patient G’s self-report at face value.

To be determined

iii. have an adequate knowledge of the patient’s health;

To be determined

iv. establish a clear diagnosis prior to initiating prescribing;

To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.

To be determined

b. Patient G refused to allow you to inform their GP

To be determined

c. you issued the prescriptions prescription in the absence of the information listed at paragraph 7(a)(i)- (v) and despite the information at paragraph 7(b) when the medication prescribed had habit forming potential.

Amended under Rule 17(6)

To be determined
d. you issued the prescriptions prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient G to their own GP.

Amended under Rule 17(6)
To be determined

Amended under Rule 17(6)
To be determined

e. in issuing the prescriptions prescription in the absence of the information listed at paragraph 7(a)(i) - (v) your prescribing practice undermined any possible support needs of Patient G pertaining to dependence upon prescribed drugs.

Amended under Rule 17(6)
To be determined

Patient H

8. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient H, in that:

Amended under Rule 17(6)
To be determined

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient H;
To be determined

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient H;
To be determined

dd. you took Patient H’s self-report at face value;
To be determined

ii. adequately assess the patient, in that:
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aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   Amended under Rule 17(6)
   To be determined

bb. you failed to consult with Patient H;
   To be determined

c. you failed to examine Patient H;
   To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient H;
   To be determined

ee. you took Patient H’s self-report at face value.
   To be determined

iii. have an adequate knowledge of the patient’s health;
   To be determined

iv. establish a clear diagnosis prior to initiating prescribing;
   To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
   To be determined

b. Patient H refused to allow you to inform their GP
   Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 8(a)(i) - (v) and despite the information at paragraph 8(b) when the medication prescribed had habit forming potential.
   Amended under Rule 17(6)
   To be determined

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient H to their own GP.
   Amended under Rule 17(6)
To be determined

e. in issuing the prescriptions prescription in the absence of the information listed at paragraph 8(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient H pertaining to dependence upon prescribed drugs.

**Amended under Rule 17(6)**

To be determined

**Patient I**

9. You inappropriately issued the online prescriptions prescription at Schedule One (`the prescriptions` `the prescription`) to Patient I, in that:

**Amended under Rule 17(6)**

To be determined

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

**Amended under Rule 17(6)**

To be determined

bb. you failed to consult with Patient I;

**To be determined**

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient I;

**To be determined**

dd. you took Patient I’s self-report at face value;

**To be determined**

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

**Amended under Rule 17(6)**

To be determined

bb. you failed to consult with Patient I;
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To be determined

cc. you failed to examine Patient I;
To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient I;
To be determined

e. you took Patient I’s self-report at face value.
To be determined

iii. have an adequate knowledge of the patient’s health;
To be determined

iv. establish a clear diagnosis prior to initiating prescribing;
To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined

b. Patient I refused to allow you to inform their GP
To be determined

c. you issued the prescriptions in the absence of the information listed at paragraph 9(a)(i)-(v) and despite the information at paragraph 9(b) when the medication prescribed had habit forming potential.
Amended under Rule 17(6)
To be determined

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient I to their own GP.
Amended under Rule 17(6)
To be determined

e. in issuing the prescriptions in the absence of the information listed at paragraph 9(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient I pertaining to dependence upon prescribed drugs.
Amended under Rule 17(6)
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To be determined

Patient J

10. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient J, in that:

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient J;
To be determined

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient J;
To be determined

dd. you took Patient J’s self-report at face value;
To be determined

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient J;
To be determined

cc. you failed to examine Patient J;
To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient J;
To be determined

ee. you took Patient J’s self-report at face value.
To be determined

iii. have an adequate knowledge of the patient’s health;
To be determined

iv. a clear diagnosis prior to initiating prescribing;
To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined

b. Patient J refused to allow you to inform their GP
To be determined

c. you issued the prescriptions in the absence of the information listed at paragraph 10(a)(i)-(v) and despite the information at paragraph 10(b) when the medication prescribed had habit forming potential.
To be determined

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient J to their own GP.
To be determined

e. in issuing the prescriptions in the absence of the information listed at paragraph 10(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient J pertaining to dependence upon prescribed drugs.
To be determined

11. On the date set out in Schedule Two you inappropriately advised Patient J to take opioid medication for the shortest possible period and to take regular breaks.
To be determined

Patient K

12. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient K, in that:
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a. you failed to:

i. obtain an adequate medical history, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   Amended under Rule 17(6)
   To be determined

   bb. you failed to consult with Patient K;
   To be determined

   cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient K;
   To be determined

   dd. you took Patient K’s self-report at face value;
   To be determined

ii. adequately assess the patient, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   Amended under Rule 17(6)
   To be determined

   bb. you failed to consult with Patient K;
   To be determined

   cc. you failed to examine Patient K;
   To be determined

   dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient K;
   To be determined

   ee. you took Patient K’s self-report at face value.
   To be determined

iii. have an adequate knowledge of the patient’s health;
To be determined

iv. establish a clear diagnosis prior to initiating prescribing;

To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.

To be determined

b. you issued the prescriptions in the absence of the information listed at paragraph 12(a)(i) - (v) when the medication prescribed had habit forming potential.

To be determined

c. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient K to their own GP.

To be determined

d. in issuing the prescriptions in the absence of the information listed at paragraph 12(a)(i) - (v) your prescribing practice undermined any possible support needs of Patient K pertaining to dependence upon prescribed drugs.

To be determined

13. On the date set out in Schedule Two you inappropriately advised Patient K to take opioid medication for the shortest possible period and to take regular breaks.

To be determined

Patient L

14. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient L, in that:

a. you failed to:

   i. obtain an adequate medical history, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

      Amended under Rule 17(6)

To be determined
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bb. you failed to consult with Patient L;
To be determined

c. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient L;
To be determined

d. you took Patient L’s self-report at face value;
To be determined

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient L;
To be determined

cc. you failed to examine Patient L;
To be determined

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient L;
To be determined

ee. you took Patient L’s self-report at face value.
To be determined

iii. have an adequate knowledge of the patient’s health;
To be determined

iv. establish a clear diagnosis prior to initiating prescribing;
To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined
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b. you issued the prescriptions in the absence of the information listed at paragraph 14(a)(i)-(v) when the medication prescribed had habit forming potential.
To be determined

c. issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient L to their own GP.
To be determined

d. in issuing the prescriptions in the absence of the information listed at paragraph 14(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient L pertaining to dependence upon prescribed drugs.
To be determined

15. On the date set out in Schedule Two you inappropriately advised Patient L to take opioid medication for the shortest possible period and to take regular breaks.
To be determined

Patient M

16. You inappropriately issued the online prescriptions prescription at Schedule One ('the prescriptions' 'the prescription') to Patient M, in that: Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
To be determined

bb. you failed to consult with Patient M;
To be determined

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient M;
To be determined
dd. you took Patient M’s self-report at face value;
To be determined

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
*Amended under Rule 17(6)*
To be determined

bb. you failed to consult with Patient M;
To be determined

c. you failed to examine Patient M;
To be determined

d. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient M;
To be determined

e. you took Patient M’s self-report at face value.
To be determined

iii. have an adequate knowledge of the patient’s health;
To be determined

iv. establish a clear diagnosis prior to initiating prescribing;
To be determined

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
To be determined

b. you issued the prescriptions in the absence of the information listed at paragraph 16(a)(i)–(v) when the medication prescribed had habit forming potential.
*Amended under Rule 17(6)*
To be determined

c. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe
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medication that had a risk of causing dependency and redirect Patient M to their own GP.

Amended under Rule 17(6)
To be determined

d. in issuing the prescriptions in the absence of the information listed at paragraph 16(a)(i)- (v) your prescribing practice undermined any possible support needs of Patient M pertaining to dependence upon prescribed drugs.

Amended under Rule 17(6)
To be determined

17. On the date set out in Schedule Two you initiated an inadequate care plan entailing the dose of the prescriptions to be increased after one week despite the risk of causing dependency.

To be determined

The Admitted Facts

14. At the outset of these proceedings, through his counsel, Mr Connolly, Dr Dharmasena made admissions to some sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these sub-paragraphs of the Allegation as admitted and found proved.

15. The Tribunal heard from Dr O, the expert called on behalf of the GMC, and Dr N, the expert witness on behalf of Dr Pooley whose case is joined to Dr Dharmasena’s case. Dr Dharmasena gave oral evidence to the Tribunal. During cross-examination he made full admissions to all of the remaining paragraphs of the Allegation. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these remaining paragraphs of the Allegation as admitted and found proved, as set out below.

The Tribunal’s Overall Determination on the Facts

16. The Tribunal has determined the facts as follows:

Patient A

1. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient A, in that:

   a. you failed to:

      i. obtain an adequate medical history, in that:
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aa. your prescribing decisions were primarily based on
the information provided in standard assessment
questionnaire templates;

    Amended under Rule 17(6)
    Admitted and found proved

bb. you failed to consult with Patient A;

    Admitted and found proved

c. you failed to contextualise the information
provided within the wider ideas, concerns and
expectations of Patient A;

    Admitted and found proved

d. you took Patient A’s self-report at face value;

    Admitted and found proved

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on
the information provided in standard assessment
questionnaire templates;

    Amended under Rule 17(6)
    Admitted and found proved

bb. you failed to consult with Patient A;

    Admitted and found proved

c. you failed to examine Patient A;

    Admitted and found proved

d. you failed to contextualise the information
provided within the wider ideas, concerns and
expectations of Patient A;

    Admitted and found proved

e. you took Patient A’s self-report at face value.

    Admitted and found proved

iii. have an adequate knowledge of the patient’s health;

    Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;

    Admitted and found proved
v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
   Admitted and found proved

b. Patient A refused to allow you to inform their GP.
   Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 1(a)(i)- (v) and despite the information at paragraph 1(b) when the medication prescribed had habit forming potential.
   Admitted and found proved

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient A to their own GP.
   Admitted and found proved

e. in issuing the prescriptions in the absence of the information listed at paragraph 1(a)(i)- (v) your prescribing practice undermined any possible support needs of Patient A pertaining to dependence upon prescribed drugs.
   Admitted and found proved

Patient B

2. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient B, in that:

a. you failed to:

   i. obtain an adequate medical history, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      Admitted and found proved

      bb. you failed to consult with Patient B;
      Admitted and found proved
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cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient B;
Admitted and found proved

dd. you took Patient B’s self-report at face value;
Admitted and found proved

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient B;
Admitted and found proved

cc. you failed to examine Patient B;
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient B;
Admitted and found proved

ee. you took Patient B’s self-report at face value.
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
Admitted and found proved

b. Patient B refused to allow you to inform their GP
Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 2(a)(i)- (v) and despite the information at
paragraph 2(b) when the medication prescribed had habit forming potential. 
**Admitted and found proved**

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient B to their own GP.
**Admitted and found proved**

e. in issuing the prescriptions in the absence of the information listed at paragraph 2(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient B pertaining to dependence upon prescribed drugs.
**Admitted and found proved**

Patient C

3. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient C, in that:

a. you failed to:

i. obtain an adequate medical history, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates; 
   **Amended under Rule 17(6)**
   **Admitted and found proved**

   bb. you failed to consult with Patient C;
   **Admitted and found proved**

   cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient C;
   **Admitted and found proved**

   dd. you took Patient C’s self-report at face value;
   **Admitted and found proved**

   ii. adequately assess the patient, in that:
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aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;  
Amended under Rule 17(6)  
Admitted and found proved

bb. you failed to consult with Patient C;  
Admitted and found proved

c. you failed to examine Patient C;  
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient C;  
Admitted and found proved

e. you took Patient C’s self-report at face value.  
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;  
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;  
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.  
Admitted and found proved

b. Patient C refused to allow you to inform their GP  
Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 3(a)(i)-(v) and despite the information at paragraph 3(b) when the medication prescribed had habit forming potential.  
Admitted and found proved

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient C to their own GP.  
Admitted and found proved
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e. in issuing the prescriptions in the absence of the information listed at paragraph 3(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient C pertaining to dependence upon prescribed drugs.
Admitted and found proved

Patient D

4. You inappropriately issued the online prescriptions prescription at Schedule One ("the prescriptions" "the prescription") to Patient D, in that: Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   Amended under Rule 17(6)
   Admitted and found proved

   bb. you failed to consult with Patient D;
   Admitted and found proved

   cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient D;
   Admitted and found proved

   dd. you took Patient D’s self-report at face value;
   Admitted and found proved

ii. adequately assess the patient, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   Amended under Rule 17(6)
   Admitted and found proved

   bb. you failed to consult with Patient D;
   Admitted and found proved

   cc. you failed to examine Patient D;
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient D;

Admitted and found proved

e. you took Patient D’s self-report at face value.

Admitted and found proved

iii. have an adequate knowledge of the patient’s health;

Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;

Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.

Admitted and found proved

b. Patient D refused to allow you to inform their GP

Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 4(a)(i)-(v) and despite the information at paragraph 4(b) when the medication prescribed had habit forming potential.

Amended under Rule 17(6)

Admitted and found proved

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient D to their own GP.

Amended under Rule 17(6)

Admitted and found proved

e. in issuing the prescriptions in the absence of the information listed at paragraph 4(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient D pertaining to dependence upon prescribed drugs.

Amended under Rule 17(6)

Admitted and found proved
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Patient E

5. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient E, in that:

**Amended under Rule 17(6)**

a. you failed to:

i. obtain an adequate medical history, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;  
   **Amended under Rule 17(6)**  
   **Admitted and found proved**

   bb. you failed to consult with Patient E;  
   **Admitted and found proved**

   cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient E;  
   **Admitted and found proved**

   dd. you took Patient E’s self-report at face value;  
   **Admitted and found proved**

ii. adequately assess the patient, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;  
   **Amended under Rule 17(6)**  
   **Admitted and found proved**

   bb. you failed to consult with Patient E;  
   **Admitted and found proved**

   cc. you failed to examine Patient E;  
   **Admitted and found proved**

   dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient E;  
   **Admitted and found proved**
ee. you took Patient E’s self-report at face value.
   **Admitted and found proved**

iii. have an adequate knowledge of the patient’s health;
   **Admitted and found proved**

iv. establish a clear diagnosis prior to initiating prescribing;
   **Admitted and found proved**

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
   **Admitted and found proved**

b. you issued the prescriptions in the absence of the information listed at paragraph 5(a)(i)-(v) when the medication prescribed had habit forming potential.
   **Amended under Rule 17(6)**
   **Admitted and found proved**

c. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient E to their own GP.
   **Amended under Rule 17(6)**
   **Admitted and found proved**

d. in issuing the prescriptions in the absence of the information listed at paragraph 5(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient E pertaining to dependence upon prescribed drugs.
   **Amended under Rule 17(6)**
   **Admitted and found proved**

e. you issued the prescription despite having reviewed Patient E’s care and recommending that opioid medication was not clinically indicated.
   **Amended under Rule 17(6)**
   **Admitted and found proved**

**Patient F**

6. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient F, in that:
   **Amended under Rule 17(6)**
a. you failed to:

i. obtain an adequate medical history, in that:

  aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;  
  Amended under Rule 17(6)  
  Admitted and found proved

  bb. you failed to consult with Patient F;  
  Admitted and found proved

  cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient F;  
  Admitted and found proved

  dd. you took Patient F’s self-report at face value;  
  Admitted and found proved

ii. adequately assess the patient, in that:

  aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;  
  Amended under Rule 17(6)  
  Admitted and found proved

  bb. you failed to consult with Patient F;  
  Admitted and found proved

  cc. you failed to examine Patient F;  
  Admitted and found proved

  dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient F;  
  Admitted and found proved

  ee. you took Patient F’s self-report at face value.  
  Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
Admitted and found proved

b. you issued the prescription in the absence of the information listed at paragraph 6(a)(i)-(v) when the medication prescribed had habit forming potential.
Amended under Rule 17(6)
Admitted and found proved

c. you issued the prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient F to their own GP.
Amended under Rule 17(6)
Admitted and found proved

d. in issuing the prescription in the absence of the information listed at paragraph 6(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient F pertaining to dependence upon prescribed drugs.
Amended under Rule 17(6)
Admitted and found proved

e. you issued the prescription despite having reviewed Patient F’s care and recommending that long term use of opioid medication was not clinically indicated.
Amended under Rule 17(6)
Admitted and found proved

Patient G

7. You inappropriately issued the online prescription at Schedule One (‘the prescription’) to Patient G, in that:
Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:
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aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient G;
Admitted and found proved

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient G;
Admitted and found proved

dd. you took Patient G’s self-report at face value;
Admitted and found proved

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient G;
Admitted and found proved

cc. you failed to examine Patient G;
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient G;
Admitted and found proved

ee. you took Patient G’s self-report at face value.
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved
v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.

Admitted and found proved

b. Patient G refused to allow you to inform their GP

Admitted and found proved

c. you issued the prescriptions prescription in the absence of the information listed at paragraph 7(a)(i)-(v) and despite the information at paragraph 7(b) when the medication prescribed had habit forming potential.

Amended under Rule 17(6)
Admitted and found proved

d. you issued the prescriptions prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient G to their own GP.

Amended under Rule 17(6)
Admitted and found proved

e. in issuing the prescriptions prescription in the absence of the information listed at paragraph 7(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient G pertaining to dependence upon prescribed drugs.

Amended under Rule 17(6)
Admitted and found proved

Patient H

8. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescription’) to Patient H, in that:

Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient H;
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Admitted and found proved

c. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient H;

Admitted and found proved

d. you took Patient H’s self-report at face value;

Admitted and found proved

ii. adequately assess the patient, in that:

a. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)

Admitted and found proved

b. you failed to consult with Patient H;

Admitted and found proved

cc. you failed to examine Patient H;

Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient H;

Admitted and found proved

ee. you took Patient H’s self-report at face value.

Admitted and found proved

iii. have an adequate knowledge of the patient’s health;

Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;

Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.

Admitted and found proved

b. Patient H refused to allow you to inform their GP

Admitted and found proved
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c. you issued the prescriptions prescription in the absence of the information listed at paragraph 8(a)(i)-(v) and despite the information at paragraph 8(b) when the medication prescribed had habit forming potential.
Amended under Rule 17(6)
Admitted and found proved

d. you issued the prescriptions prescription without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient H to their own GP.
Amended under Rule 17(6)
Admitted and found proved

e. in issuing the prescriptions prescription in the absence of the information listed at paragraph 8(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient H pertaining to dependence upon prescribed drugs.
Amended under Rule 17(6)
Admitted and found proved

Patient I

9. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient I, in that:
Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient I;
Admitted and found proved

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient I;
Admitted and found proved
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dd. you took Patient I’s self-report at face value;
Admitted and found proved

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient I;
Admitted and found proved

cc. you failed to examine Patient I;
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient I;
Admitted and found proved

e.e. you took Patient I’s self-report at face value.
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
Admitted and found proved

b. Patient I refused to allow you to inform their GP
Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 9(a)(i)-(v) and despite the information at paragraph 9(b) when the medication prescribed had habit forming potential.
Amended under Rule 17(6)
Admitted and found proved
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d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient I to their own GP.

Amended under Rule 17(6)
Admitted and found proved

e. in issuing the prescriptions in the absence of the information listed at paragraph 9(a)(i)–(v) your prescribing practice undermined any possible support needs of Patient I pertaining to dependence upon prescribed drugs.

Amended under Rule 17(6)
Admitted and found proved

Patient J

10. You inappropriately issued the online prescriptions at Schedule One (“the prescriptions”) to Patient J, in that:

a. you failed to:

i. obtain an adequate medical history, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;

Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient J;

Admitted and found proved

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient J;

Admitted and found proved

dd. you took Patient J’s self-report at face value;

Admitted and found proved

ii. adequately assess the patient, in that:

aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
Amended under Rule 17(6)
Admitted and found proved

bb. you failed to consult with Patient J;
Admitted and found proved

cc. you failed to examine Patient J;
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient J;
Admitted and found proved

ee. you took Patient J’s self-report at face value.
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
Admitted and found proved

b. Patient J refused to allow you to inform their GP
Admitted and found proved

c. you issued the prescriptions in the absence of the information listed at paragraph 10(a)(i)-(v) and despite the information at paragraph 10(b) when the medication prescribed had habit forming potential.
Admitted and found proved

d. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient J to their own GP.
Admitted and found proved

e. in issuing the prescriptions in the absence of the information listed at paragraph 10(a)(i)-(v) your prescribing practice undermined
any possible support needs of Patient J pertaining to dependence upon prescribed drugs.

**Admitted and found proved**

11. On the date set out in Schedule Two you inappropriately advised Patient J to take opioid medication for the shortest possible period and to take regular breaks.

**Admitted and found proved**

**Patient K**

12. You inappropriately issued the online prescriptions at Schedule One (‘the prescriptions’) to Patient K, in that:

a. you failed to:

   i. obtain an adequate medical history, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      **Amended under Rule 17(6)**
      **Admitted and found proved**

      bb. you failed to consult with Patient K;
      **Admitted and found proved**

   cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient K;
      **Admitted and found proved**

   dd. you took Patient K’s self-report at face value;
      **Admitted and found proved**

   ii. adequately assess the patient, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      **Amended under Rule 17(6)**
      **Admitted and found proved**

      bb. you failed to consult with Patient K;
      **Admitted and found proved**
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cc. you failed to examine Patient K;
Admitted and found proved

dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient K;
Admitted and found proved

ee. you took Patient K’s self-report at face value.
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
Admitted and found proved

b. you issued the prescriptions in the absence of the information listed at paragraph 12(a)(i)- (v) when the medication prescribed had habit forming potential.
Admitted and found proved

c. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient K to their own GP.
Admitted and found proved

d. in issuing the prescriptions in the absence of the information listed at paragraph 12(a)(i)- (v) your prescribing practice undermined any possible support needs of Patient K pertaining to dependence upon prescribed drugs.
Admitted and found proved

13. On the date set out in Schedule Two you inappropriately advised Patient K to take opioid medication for the shortest possible period and to take regular breaks.
Admitted and found proved
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Patient L

14. You inappropriately issued the online prescriptions at Schedule One ('the prescriptions') to Patient L, in that:

a. you failed to:

   i. obtain an adequate medical history, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      Admitted and found proved

      bb. you failed to consult with Patient L;
      Admitted and found proved

   ii. adequately assess the patient, in that:

      aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      Admitted and found proved

      bb. you failed to consult with Patient L;
      Admitted and found proved

      cc. you failed to examine Patient L;
      Admitted and found proved

      dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient L;
      Admitted and found proved
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ee. you took Patient L’s self-report at face value.
Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
Admitted and found proved

v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.
Admitted and found proved

b. you issued the prescriptions in the absence of the information listed at paragraph 14(a)(i)-(v) when the medication prescribed had habit forming potential.
Admitted and found proved

c. issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient L to their own GP.
Admitted and found proved

d. in issuing the prescriptions in the absence of the information listed at paragraph 14(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient L pertaining to dependence upon prescribed drugs.
Admitted and found proved

15. On the date set out in Schedule Two you inappropriately advised Patient L to take opioid medication for the shortest possible period and to take regular breaks.
Admitted and found proved

Patient M

16. You inappropriately issued the online prescriptions prescription at Schedule One (‘the prescriptions’ ‘the prescription’) to Patient M, in that:
Amended under Rule 17(6)

a. you failed to:

i. obtain an adequate medical history, in that:
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aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
   Amended under Rule 17(6)
   Admitted and found proved

bb. you failed to consult with Patient M;
   Admitted and found proved

cc. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient M;
   Admitted and found proved

dd. you took Patient M’s self-report at face value;
   Admitted and found proved

ii. adequately assess the patient, in that:

   aa. your prescribing decisions were primarily based on the information provided in standard assessment questionnaire templates;
      Amended under Rule 17(6)
      Admitted and found proved

   bb. you failed to consult with Patient M;
      Admitted and found proved

   cc. you failed to examine Patient M;
      Admitted and found proved

   dd. you failed to contextualise the information provided within the wider ideas, concerns and expectations of Patient M;
      Admitted and found proved

   ee. you took Patient M’s self-report at face value.
      Admitted and found proved

iii. have an adequate knowledge of the patient’s health;
      Admitted and found proved

iv. establish a clear diagnosis prior to initiating prescribing;
    Admitted and found proved
v. formulate an adequate and appropriate treatment plan prior to initiating prescribing.  
Admitted and found proved

b. you issued the prescriptions in the absence of the information listed at paragraph 16(a)(i)-(v) when the medication prescribed had habit forming potential.  
Amended under Rule 17(6)  
Admitted and found proved

c. you issued the prescriptions without adequate and appropriate safeguarding, in that you failed to decline to prescribe medication that had a risk of causing dependency and redirect Patient M to their own GP.  
Amended under Rule 17(6)  
Admitted and found proved

d. in issuing the prescriptions in the absence of the information listed at paragraph 16(a)(i)-(v) your prescribing practice undermined any possible support needs of Patient M pertaining to dependence upon prescribed drugs.  
Amended under Rule 17(6)  
Admitted and found proved

17. On the date set out in Schedule Two you initiated an inadequate care plan entailing the dose of the prescriptions to be increased after one week despite the risk of causing dependency.  
Admitted and found proved

Determination on Impairment - 16/07/2019

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 Dharmasena’s fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

3. Dr Dharmasena provided his own witness statement to the Tribunal on 1 July 2019 and also gave oral evidence at the hearing. The statement detailed a number of Continuing Professional Development (CPD) courses he had undertaken.
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4. Within his witness statement, Dr Dharmasena stated that he had been inexperienced in the field of online prescribing and felt that the patient questionnaires were able to capture adequate information to allow him to prescribe medication. He stated that the questionnaires seemed to ask similar questions to what he would ask in a face to face consultation. Dr Dharmasena said that, with hindsight, he appreciated that generally a single questionnaire alone would not provide adequate and appropriate information. He stated that he now realised the importance of having the patients’ own GPs involved in the prescribing process to ensure sharing of relevant information. Dr Dharmasena said that he should have been more vigilant and pro-active about this, and acted more forcefully in requiring patients to consent for information sharing and their own GP’s involvement. He stated that this was a mistake on his part. Dr Dharmasena said that he had reflected and learned from his mistakes, such that he could see that his performance whilst working at White Pharmacy had fallen short of the standards expected of a competent GP.

5. Dr Dharmasena told the Tribunal that, with the benefit of hindsight, he would take different actions in respect of the prescribing of opiate medication. He stated that he now had a clearer awareness of the risks of addiction and of the current guidelines about alternative treatment options that should be explored. Dr Dharmasena told the Tribunal that he would ensure more checks and balances were in place in the system to ensure appropriate reviews and only prescribe small amounts of opiate medication when required. Dr Dharmasena stated that he believed, at the time, that his actions in 2017 were appropriate and adequate, but that he can now see that this was not the case. Dr Dharmasena referred to the different consultation model of White Pharmacy, which he had not encountered before in his mainstream NHS practice. He stated that he had undertaken education and research and that he would now be cautious in his approach to prescribing, he would follow national guidelines, and only return to online prescribing where there was clear communication with patients’ GPs and where information from a patient could be corroborated. Dr Dharmasena also said that his role as Clinical Director at White Pharmacy had been focused on developing new protocols for new medications.

Documentary Evidence

6. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to: a record of a telephone conversation between Dr Dharmasena and CQC advisers dated 22 May 2017; the referral from the CQC on 25 May 2017; complaint letters from various GPs in respect of the medication issued to their patients by Dr Dharmasena; employer response from NHS England dated 15 August 2017; White Pharmacy records in respect of Patients A to M; the CQC recommendations for White Pharmacy based on their inspection reports from January 2017, March 2017 and May 2017; and a number of guidance documents, including The National Institute for Health and Care Excellence
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(NICE) guidelines in respect of sprains and strains, low back pain and neuropathic pain.

7. In addition, the Tribunal received further evidence at the impairment stage in the form of a number of positive testimonials about Dr Dharmasena from colleagues, employers and members of his family, all of which the Tribunal has read.

Expert Witness Evidence

8. The Tribunal received evidence from two expert witnesses, who both gave oral evidence to the Tribunal. Both were instructed to assist the Tribunal in understanding the professional standards to be expected of a GP.

9. The GMC expert witness was Dr O, a GP, GP appraiser and the Clinical Research Director for Spectrum CIC - a national social enterprise providing primary care to vulnerable groups. Dr O provides primary care services in both mainstream general practice and to patients residing in prisons and immigration removal centres. Dr O’s first report in respect of Dr Dharmasena is dated 11 December 2017 and two supplementary reports are dated 18 April 2018 and 14 February 2019.

10. The Tribunal also heard from Dr N, a full time GP Principal in a North London Practice, who was the expert witness on behalf of Dr Pooley whose case is joined to Dr Dharmasena’s case. The matters raised by both expert witnesses were also relevant to Dr Dharmasena’s case. Dr N completed his undergraduate training in Australia and postgraduate GP training in Hertfordshire, UK. Dr N is also a member of the Royal College of General Practitioners. Dr N completed a report dated 13 June 2019; an undated addendum report in respect of Dr Pooley; had a joint discussion with Dr O on 24 June 2019 in relation to Dr Pooley’s case and provided a summary of their opinions; and, following his oral evidence, provided a brief clarification document dated 8 July 2019 in respect of the appropriateness of a prescription of Solpadol, an opioid medication, as a treatment for migraine.

11. The Tribunal noted that there was very little dispute between the two experts. In general, it found both to be knowledgeable and clear witnesses. Dr O’s opinion evidence was preferred to Dr N’s evidence because the latter was grounded in normal GP prescribing rather than the online prescribing process in this case.

12. In oral evidence, Dr O reiterated his written opinion that it would be inappropriate to prescribe opiate medication in circumstances where there was no potential for a face to face consultation and where there was no consent to inform the patient’s GP. He spoke about the need for adequate assessment to take place and for appropriate safeguards to be in place in order to reduce the risks of drug dependency as opiate medication has habit forming potential. He acknowledged that it might be appropriate to prescribe a small amount of opiate medication as a ‘one last’ prescription to cover the short period before the patient can see their own GP
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but that, in his opinion, this was not what had happened in terms of the Allegation faced by Dr Dharmasena. Dr O opined that the care provided by Dr Dharmasena fell seriously below the standard expected of a reasonably competent GP.

GMC Submissions

13. Mr Sastry submitted that Dr Dharmasena’s fitness to practise is currently impaired. He stated that Dr Dharmasena had been prescribing harmful drugs to patients without knowledge of their health. Mr Sastry submitted that Dr Dharmasena had breached basic principles of medicine and the misconduct was serious.

14. Mr Sastry referred the Tribunal to paragraph 16(a) of the current edition of Good Medical Practice (2013) (‘GMP’):

"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..."

He referred to the mandatory language within this paragraph of the guidance, "you must", and submitted that this was used for an overriding duty or principle. Mr Sastry also referred to the guidance regarding remote prescribing. He submitted that the guidance was in place to ensure patient safety and it had not been followed by Dr Dharmasena.

15. Mr Sastry referred to Dr Dharmasena’s treatment of Patient K, where a complaint letter had been received by the GMC from Patient K’s GP. Mr Sastry stated that Dr Dharmasena had prescribed dihydrocodeine to Patient K, an opioid medication with the potential for the patient to suffer respiratory problems that could possibly result in death. Patient K had a history of depression and the GP complaint letter stated that Patient K had had an addiction to prescription medication. Mr Sastry stated that Patient K had said she had migraines on the online questionnaire. The Tribunal has heard that opiates should not have been prescribed for migraine in this instance. Mr Sastry stated that, whilst it may be that no serious harm was caused, there was the chance of serious harm given the absence of proper safeguarding. Mr Sastry submitted that the opioid medication was issued by Dr Dharmasena in circumstances where there was no consent to inform the patient’s GP.

16. Mr Sastry referred to Dr O’s evidence that Dr Dharmasena’s actions fell seriously below the expected standard of a reasonably competent GP. He submitted that each medication prescribed to each of the patients could have been prescribed to a patient with an opiate addiction. Mr Sastry stated that this was why he submitted that the conduct was serious and might have caused serious harm.
17. Mr Sastry also referred the Tribunal to paragraph 15(a) of GMP:

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

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

He stated that he placed emphasis on the need to “adequately assess”, which also featured in the Allegation that Dr Dharmasena faces. Mr Sastry submitted that Dr Dharmasena has breached this principle of GMP.

18. Mr Sastry referred to the evidence heard that there is a widespread issue regarding addiction to prescription medication. He referred to Dr O’s evidence that, even if Dr Dharmasena had not been aware of the full scale of the problem, a doctor would have a basic, degree level knowledge of the dangers of opiate medication/controlled drugs. Mr Sastry asked the Tribunal to bear this in mind.

19. Mr Sastry referred to the comments of Mrs Justice Cox in the case of CHRE v NMC and Grant [2011] EWHC 927, including that it was essential not to lose sight of the fundamental consideration, 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.

20. Mr Sastry submitted that a finding of impairment was needed to maintain public confidence in the profession and uphold proper professional standards.

21. Mr Sastry acknowledged that there had been no previous criticism of Dr Dharmasena’s practice prior to these matters. He stated that Dr Dharmasena issued fewer prescriptions than Dr Pooley, the case joined to this one, but that a large number of patients were still involved and the misconduct was serious.

22. Mr Sastry stated that during some of Dr Dharmasena’s time at White Pharmacy he was acting as the Clinical Director. He said that Dr Dharmasena’s responsibilities were difficult to ascertain but the CQC had raised concerns. Mr Sastry submitted that Dr Dharmasena had not really ‘grasped the nettle’ regarding the concerns.

23. Mr Sastry stated that Dr Dharmasena did not initially admit most of the charges. He said that Dr Dharmasena, in his oral evidence, consistently acknowledged that he should not have acted as he did. Mr Sastry submitted that this may indicate that the level of Dr Dharmasena’s insight is not complete. Mr Sastry
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told the Tribunal that the issue of online prescribing will have an increasing role to
doctors and patients in the future.

24. Mr Sastry submitted that Dr Dharmasena’s fitness to practise is currently
impaired and there is a risk of repetition.

Submissions on Dr Dharmasena’s behalf

25. Mr Connolly submitted that Dr Dharmasena has accepted that his failings and
the concerns for patients being placed at risk in the past would justify a finding of
impairment.

26. Mr Connolly stated that it was nevertheless important for the Tribunal to
consider some of the relevant circumstances. He submitted that Dr Dharmasena has
always understood the seriousness of what has happened and that he was ashamed
and appalled that what he did might have caused harm to patients. Mr Connolly
submitted that there was a lack of judgement but this was not a case where there
was a deliberate disregard for patient safety.

27. In relation to why the Allegation was not admitted in its entirety at the start of
the hearing, Mr Connolly stated that Dr Dharmasena perhaps failed to distinguish
between an acceptance of the charges and his insistence that his conduct in 2017 was
genuinely motivated to help his patients. He stated that Dr Dharmasena had been in a
new situation and he had to make judgements in an unfamiliar setting. Mr Connolly
submitted that Dr Dharmasena understands now that he should not have provided those
prescriptions and knows they were not justifiable.

28. Mr Connolly stated that Dr Dharmasena has accepted that the model was
fundamentally flawed and that this understanding was genuine and unreserved. Further,
White Pharmacy was not Dr Dharmasena’s own business and he had joined a long-
standing model with policies and procedures in place; other senior practitioners had
been prescribing within this model for some time. Mr Connolly stated that
Dr Dharmasena did not benefit financially from the decision to prescribe rather than
deciding to prescribe.

29. In relation to the wider concerns regarding addiction to prescription medication,
Mr Connolly stated that an article referred to by Dr O observed that further education
was required (as at 2017) to create awareness within the profession of this issue. Mr
Connolly submitted that Dr Dharmasena knew that opioid medication has habit-forming
potential, but the Tribunal may accept that Dr Dharmasena has addressed this in the
steps he has taken to remediate.

30. Mr Connolly stated that the prescriptions issued by Dr Dharmasena were mostly
one or two prescriptions per patient. He submitted that the approach that
Dr Dharmasena had developed was one that encouraged each patient to seek a face to
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face consultation with their GP. Mr Connolly stated that in all of the White Pharmacy records, apart from Patient C, there was a direct reference in each of the reviews to a request, and sometimes insistence, that the patient’s GP be contacted.

31. Mr Connolly noted that consent to contact a patient’s GP would not obviate the risk but it would create another safeguard. He referred to Dr O’s evidence that Dr Dharmasena was trying to encourage his patients to provide consent for White Pharmacy to inform their GP. Mr Connolly suggested that Dr Dharmasena’s perception at the time was that obtaining consent would have met the CQC’s concerns. He stated that Dr Dharmasena stopped prescribing opioid medication before the CQC required the White Pharmacy to do so.

32. In relation to Dr Dharmasena being appointed as Clinical Director, Mr Connolly invited the Tribunal to consider the actual evidence. He submitted that there was no evidence that Dr Dharmasena had any management function or control over the organisation. Mr Connolly stated that Dr Dharmasena gave advice, as did Dr Pooley, but the advice was not followed. He submitted that Dr Dharmasena was clearly trying to change the model but his suggestions were not widely adopted and he left a relatively short time after his appointment to Clinical Director.

33. Mr Connolly submitted that the events took place some two years ago and referred to the references/testimonials that have been provided to demonstrate Dr Dharmasena’s active attempts to change his practice.

34. Mr Connolly concluded that, having identified those features, it is accepted that there is still public interest in marking Dr Dharmasena’s misconduct with a finding of impairment.

The Relevant Legal Principles

35. 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.

36. 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 that was serious; and then whether the finding of that misconduct could lead to a finding of impairment.

37. The Tribunal must determine whether Dr Dharmasena’s fitness to practise is impaired today, taking into account Dr Dharmasena’s conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.
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38. The Legal Assessor referred the Tribunal to the case of *Martin v GMC* [2011] EWHC 3204 (Admin) that misconduct requires bad faith/moral turpitude or gross incompetence/gross negligence and does not always amount to impairment.

39. The Tribunal was also reminded of the approach referred to in the case of *Grant*:

"Do our findings of fact in respect of the doctor's misconduct... show that his/her fitness to practise is impaired in the sense that s/he:

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

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

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

d. [not relevant to this case]"

Tribunal’s comments regarding White Pharmacy

40. The Tribunal observed that both expert witnesses agree White Pharmacy’s operating model was inappropriate in itself and did not allow the opportunity for face to face consultations. Patients placed orders for medication they wanted from the website and filled in an online questionnaire with details of their medical history. Doctors who worked for White Pharmacy then considered the questionnaires and prescribed medication.

41. The Tribunal accepted Dr O’s opinion that it was inappropriate to prescribe in the way that White Pharmacy operated given the doctor did not have sufficient reliable information to enable them to prescribe safely. The doctors working at White Pharmacy did not have access to the patients’ GP records and some patients did not provide consent for the prescribing information to be sent to their GPs. However, the Tribunal was clear that the lack of safeguards in the system did not negate the responsibility on a doctor to work within the guidance set out by the GMC as to the requirements for safe remote prescribing.

The Tribunal’s Determination on Impairment

Misconduct

42. The Tribunal first considered whether Dr Dharmasena’s actions amount to misconduct.
43. The Tribunal has found proved that Dr Dharmasena inappropriately issued a number of online prescriptions of opioid medication to Patients A to M when this medication had habit forming potential. Dr Dharmasena did not decline to prescribe the medication and redirect the patients to their GP despite the risk of the medication causing dependency and the fact that it might have undermined any support needs that the patients could have required. The Tribunal had regard to the complaint letters that had been received from GPs who expressed concerns about how Dr Dharmasena had prescribed to their patient.

44. The Tribunal was mindful of Dr O’s evidence in which he opined that Dr Dharmasena’s actions were seriously below the expected standard of a reasonably competent GP. It noted that Dr Dharmasena has also accepted that his actions were seriously below those standards.

45. The Tribunal had regard to the guidance, including paragraph 16(a) of GMP as quoted above. It was of the view that the guidance was clear that it was imperative for a doctor to have adequate knowledge of a patient’s health before prescribing drugs to them. The Tribunal was also conscious of the GMC guidance entitled ‘Good practice in prescribing medicines and devices’ (2013), including paragraphs 60 and 61:

"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...

61. 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 assessment
   c. whether you have access to the patient’s medical records."

46. The Tribunal was of the view that it was a fundamental principle that a doctor would need to have the relevant information available to him or her in order to allow them to make a safe and appropriate decision. The Tribunal concluded that Dr Dharmasena did not have the relevant information when he was working at White Pharmacy. It was concerned that there was a clear risk in prescribing opioid medication in such a situation.

47. The Tribunal determined that it should have been obvious to Dr Dharmasena at the very start of his online prescribing that he did not have sufficient verifiable information available to him. He was a trained GP and was aware of the
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requirements as set out in the guidance. The Tribunal determined that Dr Dharmasena had applied a different standard of prescribing in his online work to that which he would have applied to a face to face consultation with a patient given there had been no previous concerns about his practice. The Tribunal was of the view that Dr Dharmasena’s actions were reckless.

48. The Tribunal also noted that Dr Dharmasena became the Clinical Director for White Pharmacy in May 2017. Dr Dharmasena told the Tribunal that this role did not have the same sort of power or responsibility that it may have in other organisations. The Tribunal noted that Dr Dharmasena thought he was going to be able to change the system at White Pharmacy but continued to prescribe under the flawed operating model.

49. The Tribunal has concluded that Dr Dharmasena’s conduct fell so far short of the standards of conduct reasonably to be expected of a doctor as to amount to misconduct.

Impairment by reason of misconduct

50. Having found that the facts found proved amounted to misconduct, the Tribunal went on to consider whether Dr Dharmasena’s fitness to practise is currently impaired by reason of his misconduct.

51. The Tribunal had regard to Dr Dharmasena’s efforts in relation to remediation. It noted the CPD undertaken by Dr Dharmasena, including “Opioid analgesic dependency - June 2018” and “Safe Prescribing - April 2019”. However, the Tribunal had no information as to what the courses contained, the CPD was not focused in relation to the allegations, and there was no evidence of Dr Dharmasena having reflected on what he had learned. The Tribunal also had regard to the positive testimonials that Dr Dharmasena provided. It found that Dr Dharmasena had taken some steps towards remediation of his misconduct but that more was required.

52. The Tribunal noted that Dr Dharmasena initially made a small number of admissions to the Allegation but later made full admissions during cross-examination. It noted Mr Connolly’s submissions that Dr Dharmasena did not deliberately put patients at risk and that his actions were caused by a lack of judgement. The Tribunal found Dr Dharmasena’s poor judgement was so serious that it put patients at risk.

53. The Tribunal was of the view that Dr Dharmasena can now see that his actions were wrong but he has not yet accepted that he should have known at the time that they were wrong. The Tribunal did not feel that there was adequate reflection on Dr Dharmasena’s part. The Tribunal concluded that Dr Dharmasena,
having only admitted his failings in cross-examination, is only now starting to develop insight but it is limited at this stage.

54. The Tribunal determined that, with the benefit of hindsight, Dr Dharmasena does understand the risks that resulted of his unsafe prescribing but there remains a need for him to take responsibility for his actions. Dr Dharmasena had a responsibility to prescribe safely irrespective of the prescribing of other doctors at White Pharmacy. He should not have prescribed opioid medications during his time at White Pharmacy. He also needs to demonstrate an understanding of the safeguards required for online prescribing. The Tribunal determined that there remains a risk of repetition given the lack of full insight.

55. The Tribunal had regard to what a reasonably informed member of the public would think of this case. It considered that such individuals would be appalled by the online prescribing undertaken by Dharmasena. The Tribunal was concerned that remote prescribing without safeguards was a route for patients with potential addiction to obtain large amounts of opioid medication. The Tribunal was conscious of the risks surrounding controlled drugs.

56. The Tribunal determined that Dr Dharmasena’s fitness to practise is impaired by reason of misconduct. It was of the view that there was impairment by reason of an ongoing risk of harm, the need to maintain public confidence in the profession and to maintain proper professional standards and conduct for members of the profession. The breach of the fundamental principles set out in the guidance was severe and Dr Dharmasena’s actions fell seriously below the expected standard on a number of occasions. The Tribunal found there to be a clear public interest in a finding of impairment in these circumstances, given the risk to patients and in order to safeguard the reputation of the profession.

Determination on Sanction - 18/07/2019

1. Having determined that Dr Dharmasena’s 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.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

3. The Tribunal received further evidence on behalf of Dr Dharmasena in the form of a further statement and reflective synopsis of CPD work undertaken.

4. Within the statement, Dr Dharmasena stated that the complaint and subsequent events had made him evaluate his clinical practice. He said that he could
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not apologise enough for the problems that his actions and omissions had caused patients; he was only ever trying to help patients deal with their symptoms and conditions. Dr Dharmasena clarified that his intentions were never to encourage medication misuse or abuse, nor to circumvent the hard work and effort of the respective GPs.

5. Dr Dharmasena referred to the GP work he had completed since the concerns were raised. By dealing with each patient individually, to use the consultation as an opportunity to review and understand the relevant guidelines, and then to discuss with a senior clinician when appropriate, he felt he was slowly addressing and remediating where he had previously made mistakes. Dr Dharmasena stated that he was able to appreciate the various safeguards in place in a GP environment in order to ensure that the way he practiced at White Pharmacy would never recur.

6. Dr Dharmasena stated that he could still not fully explain his actions during his time at White Pharmacy. He stated that he had gone into it without any experience or knowledge of online pharmacy or private prescribing, and a degree of naivety. Dr Dharmasena recognised that even then, as a competent GP, he should have removed himself from that situation sooner. Dr Dharmasena stated that he had hoped that with his experience and acting medical director position that White Pharmacy would start listening to his advice and requests, but in hindsight, he should have declined and left earlier.

GMC Submissions

7. Mr Sastry submitted that the appropriate sanction would be suspension in this case. He referred to a number of paragraphs within the Sanctions Guidance (6 February 2018) (‘the SG’), including paragraph 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.”

Mr Sastry submitted that there had been a serious and a persistent breach of the guidance and that patients were put at risk. He stated that Dr Dharmasena has potentially undermined the trust that the public place in doctors.

8. Mr Sastry acknowledged that the testimonials show that Dr Dharmasena is well-regarded as a doctor. He stated that a number of the aggravating factors suggested in the SG did apply in this case and submitted that Dr Dharmasena’s lack of insight was a major issue. He said that Dr Dharmasena has not demonstrated the timely development of insight. Mr Sastry referred to the Tribunal’s comments at the impairment stage that Dr Dharmasena’s poor judgement had been so serious as to put patients at risk and that his insight was only now starting to develop.
9. Mr Sastry submitted that Dr Dharmasena’s case was far too serious for the Tribunal to take no action. He stated that there were no exceptional circumstances and that it was appropriate for the Tribunal to move to the next least restrictive sanction.

10. Mr Sastry submitted that conditions would not adequately reflect the seriousness of Dr Dharmasena’s misconduct. He reminded the Tribunal of its findings that Dr Dharmasena’s actions were reckless and that it should have been obvious to him that he should not have started prescribing opiates without the necessary safeguards. Mr Sastry submitted that conditions would be inadequate to address the concerns or to maintain public confidence in the profession. He submitted that, given the lack of insight, conditions were also unlikely to be unworkable.

11. Mr Sastry referred the Tribunal to paragraph 92 of the SG:

"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..."

He reminded the Tribunal of its findings that Dr Dharmasena’s actions were serious and that it was a fundamental principle that a doctor has to have the relevant information before them in order to make safe and appropriate prescribing decisions. Mr Sastry suggested that the Tribunal’s comments in its determination on impairment would indicate that suspension is the correct sanction in terms of the need to safeguard the repetition of the profession.

12. With reference to paragraph 97 of the SG, Mr Sastry identified a number of facts which might indicate that suspension may be appropriate. He submitted that there had been a serious breach of GMP, in circumstances where Dr Dharmasena’s conduct was not fundamentally incompatible with his continued registration. Mr Sastry stated that Dr Dharmasena had not developed as much insight as the Tribunal would have liked to see and the risk of repetition was a matter for the Tribunal to consider.

13. Mr Sastry stated that there were a number of factors for the Tribunal to consider when determining the duration of any suspension. He submitted that it should consider the seriousness of the findings, including the extent to which Dr Dharmasena departed from the principles of GMP and the extent to which his actions risk patient safety or public confidence.

14. Mr Sastry stated the Tribunal had found that a reasonably informed member of the public would be appalled by the online prescribing that took place. He submitted that this was an example of why suspension was required, in order to maintain public confidence and uphold proper professional standards. Mr Sastry
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stated that this was a case where the need to uphold those principles would only be satisfied by a sanction of suspension.

Submissions on Dr Dharmasena’s behalf

15. Mr Connolly submitted that this was not a case that met the threshold for erasure of Dr Dharmasena’s name from the Medical Register. He stated that the conditions that might make it appropriate to suspend Dr Dharmasena’s registration are met but it does not follow that it is therefore appropriate to do so. In this case suspension would be disproportionate. Mr Connolly indicated that it was a question for the Tribunal whether public confidence might be upheld by the sanction of conditions.

16. Mr Connolly explained that the further reflective statement was intended to address the concerns that Dr Dharmasena has not yet addressed and to provide the Tribunal with some detail of the CPD modules he has completed.

17. Mr Connolly submitted that it is in the public interest to allow hard-working conscientious, empathetic practitioners like Dr Dharmasena to continue in practice. He referred to the testimonials and stated that these demonstrated that Dr Dharmasena was committed to providing a valuable service to his patients and there have never been any concerns or complaints about his work outside of White Pharmacy.

18. Mr Connolly referred the Tribunal to paragraph 82(d) of the SG:

"Conditions are likely to be workable where:

...d. the doctor has the potential to respond positively to remediation, or retraining, or to their work being supervised."

He submitted that Dr Dharmasena has been complying with strict conditions not to prescribe opioid or neuropathic medication since August 2017. There has been supervision of his opioid prescribing practice for a lengthy period. Mr Connolly submitted that the Tribunal can be satisfied that Dr Dharmasena will comply with conditions.

19. Mr Connolly submitted that, whilst the admissions have been late, they are unreserved. He stated that Dr Dharmasena made the admissions as he has acknowledged and accepted the specific failings identified in each of the charges.

20. Mr Connolly submitted that the issues do not relate to Dr Dharmasena’s ordinary practice as a GP, only in relation to the discrete area of online prescribing where he has not applied the otherwise high standards that he maintained. Mr Connolly clarified that the lack of insight relates to the application of the
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guidelines within that setting and no other. He confirmed that Dr Dharmasena’s current employment does not involve online consultation and that he either works in acute response within the hospital setting or within patients’ homes and always with a team of other practitioners. Mr Connolly stated that the risks that applied at White Pharmacy could not apply to his current position even if they began to offer online consultations.

21. Mr Connolly submitted that the particular risks in this case would not be present within an NHS setting and the public would be safeguarded. Dr Dharmasena had made it plain that he would not support or work with any organisation offering private online consultation and a condition could be applied to ensure this does not occur. Mr Connolly also suggested a number of other conditions including that Dr Dharmasena’s practice could be supervised and/or a restriction placed on his prescribing of opiates.

22. Mr Connolly asked the Tribunal to accept that Dr Dharmasena’s written apology was genuine. He stated that the comments within Dr Dharmasena’s testimonials reflect some insight and demonstrate continued work to learn from his experience. Mr Connolly referred to the Tribunal’s comments on impairment and submitted that it might be that supervision would support Dr Dharmasena in applying the sufficient focus required.

23. Mr Connolly spoke of Dr Dharmasena’s long term career plans, including that he could hopefully obtain a permanent position at the Lime Surgery, which would be under the supervision of the two senior medical practitioners. He stated that Dr Dharmasena would also like to continue working with the Acute Response Team. Mr Connolly submitted that the concerns raised were more likely to be addressed if Dr Dharmasena remained within the identified NHS practices rather than if he simply ceased to practise for a period of suspension.

24. Mr Connolly stated that Dr Dharmasena was involved with White Pharmacy for a relatively short time and he terminated that role himself. If a suspension is necessary, Mr Connolly asked the Tribunal to consider the length of any suspension given that a longer suspension may affect Dr Dharmasena’s ability to return to a safe and secure work environment. He made reference to the personal hardships that Dr Dharmasena will face if he is unable to continue working as a GP. He submitted that a shorter suspension would reflect the gravity of the failures but ensure a return to this safe practising environment.

The Relevant Legal Principles

25. The Tribunal was reminded that each case should be decided on its own merits when deciding the appropriate sanction. With reference to the case of Harry v GMC [2006] EWHC 3050, an approach whereby the Tribunal or parties seek to impose a similar sanction that was imposed in an apparently similar case is not to be undertaken.
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26. The Legal Assessor referred to the decision in *Bolton v Law Society* [1993] EWCA Civ 32, where it has been commented that proportionality includes the principles that the reputation of a profession is more important than the fortunes of an individual member of that profession.

27. The Tribunal is entitled to look beyond the charges that the doctor is facing to take into account the doctor’s overall professional history to come to a conclusion, on sanction, which is fair and in the public interest (*Fernando v GMC* [2014] EWHC 1664).

The Tribunal’s Determination on Sanction

28. The decision as to the appropriate sanction to impose, if any, in this case is a matter for this Tribunal exercising its own judgement.

29. In reaching its decision, the Tribunal has taken account of the SG. It has borne in mind that the purpose of the sanctions is not to be punitive, but to protect patients and the wider public interest, although they may have a punitive effect.

30. The Tribunal gave careful consideration to the aggravating and mitigating factors present in Dr Dharmasena’s case.

31. In mitigation the Tribunal had regard to the following factors:

   - The Tribunal has seen a number of positive testimonials on behalf of Dr Dharmasena which emphasise that he is a well-regarded practitioner.
   - Dr Dharmasena has expressed regret for his actions and has apologised for his misconduct.
   - The Tribunal acknowledged the full blanket admissions made by Dr Dharmasena that were made without reservation. However, it also noted that the admissions took place during cross-examination rather than at the start of this hearing.

32. The Tribunal has heard from Dr Dharmasena that he spent approximately 25 minutes per patient/prescription during his work at White Pharmacy. The Tribunal also noted that Dr Dharmasena was beginning to take appropriate measures in his prescribing at White Pharmacy but his actions were inadequate because he simply could not have prescribed opiates safely to patients in that system. The Tribunal acknowledged that Dr Dharmasena was attempting to make changes and it believed that he went into the work in order to try to help patients. Nevertheless, Dr Dharmasena’s actions in prescribing opioid medication without the necessary safeguards were inadequate and he should not have issued those prescriptions in the first place.

MPT: Dr DHARMASENA
33. The Tribunal balanced the mitigating factors against what it considered to be the aggravating factors in this case:

- The misconduct in question took place in relation to 13 patients. The Tribunal considered that its findings in respect of the misconduct were an aggravating factor given the seriousness of the conduct and the need to satisfy the public interest in the specific circumstances of this case. It reiterated its comments that Dr Dharmasena should have looked at the system at White Pharmacy and realised that he should not have prescribed opioid medication without the appropriate safeguards in place. There is a clear public interest arising from the need to maintain proper professional standards and to uphold the reputation of the profession.

- The Tribunal noted that Dr Dharmasena was appointed as the Clinical/Medical Director of White Pharmacy from May 2017 until he left in August 2017. He was aware of the CQC concerns and yet continued to prescribe opiates in these unsafe circumstances.

34. The Tribunal expressed concerns regarding Dr Dharmasena’s insight. It was of the view that it had not developed in a timely manner. With reference to its determination on impairment, the Tribunal has found that Dr Dharmasena does have some insight into his actions and has undertaken some steps towards remediation; however, both are incomplete at this stage.

35. The Tribunal had regard to the further statement and reflective synopsis of CPD work undertaken by Dr Dharmasena. It recognised that the statement shows that Dr Dharmasena has given some thought to what went wrong in 2017. The Tribunal was also assisted by Dr Dharmasena’s explanation of the courses he has undertaken. Whilst this was a positive step forward, the Tribunal was of the view that there is still progress to be made before Dr Dharmasena can demonstrate that he has sufficient insight into the deficiencies identified. The Tribunal wished to make it clear that it considered the deficiencies to be remediable and that there is the potential that Dr Dharmasena will successfully be able to remedy them.

**No action**

36. In coming to its decision as to the appropriate sanction, if any, to impose in Dr Dharmasena’s case, the Tribunal first considered whether to conclude the case by taking no action.

37. The Tribunal determined that, in view of the serious nature of its findings at the facts and impairment stages, it would be wholly inappropriate to conclude this case by taking no action. It could find no exceptional circumstances such to justify taking no action.

**Conditions**
38. The Tribunal next considered whether it would be sufficient to impose conditions on Dr Dharmasena’s registration. It has borne in mind that any conditions imposed must be appropriate, proportionate, workable and measurable.

39. The Tribunal has found that, as an experienced GP, Dr Dharmasena’s misconduct was serious and reckless. It fell seriously below the expected standards on a number of occasions. It balanced this with the partial insight and remediation that Dr Dharmasena has displayed and the importance of not removing a GP from practise for any longer than is necessary.

40. The Tribunal noted that Dr Dharmasena has complied with interim conditions and was of the view that conditions could have been workable in principle. However, the imposition of conditions on Dr Dharmasena’s registration would not adequately address the public interest concerns. The Tribunal was of the view that a reasonably informed member of the public would be appalled by Dr Dharmasena’s behaviour and that the seriousness of the misconduct was such that conditions would not be sufficient in order to uphold proper professional standards or to maintain public confidence in the profession.

41. The Tribunal determined that it would not be appropriate or proportionate to direct the imposition of conditions on Dr Dharmasena’s registration.

Suspension

42. The Tribunal then went on to consider whether suspending Dr Dharmasena’s registration would be appropriate and proportionate.

43. The Tribunal had regard to its findings at the facts and impairment stages and to the aggravating and mitigating factors that it has identified. The Tribunal was of the view that Dr Dharmasena’s actions in inappropriately prescribing opioid medication to 13 patients were serious. It determined that Dr Dharmasena had risked patient safety and damaged public confidence in the profession.

44. The Tribunal was conscious of Dr Dharmasena’s role as the Clinical/Medical Director at White Pharmacy from May to August 2017. The Tribunal was of the view that the public interest concerns were increased given the insufficient insight shown by Dr Dharmasena despite the role he held. The Tribunal concluded that the position as Clinical/Medical Director denoted a degree of responsibility and the CQC directly raised their concerns with him in May 2017.

45. The Tribunal also had regard to the developing insight and remediation shown by Dr Dharmasena. It was of the view that there was still progress to be made before sufficient insight and full remediation are attained.
The Tribunal balanced these factors against the public interest in not removing a GP from practice for any longer than is necessary. The Tribunal had regard to the mitigating factors listed above including the positive testimonials, the blanket admissions made and the apology expressed by Dr Dharmasena. It also noted that Dr Dharmasena has been working under conditions since the concerns were raised without further complaints.

The Tribunal took account of paragraph 91 of the SG:

"Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention."

The Tribunal was of the view that suspension in this case would send out the right signal to both the public and to other members of the profession. The Tribunal has carefully balanced the issues before it but ultimately it has determined that suspension of Dr Dharmasena’s registration is necessary to uphold proper professional standards and to maintain public confidence in the profession. It is of the view that this sanction is sufficient to mark the public interest concerns.

The Tribunal concluded that erasure of Dr Dharmasena’s name from the Medical Register would be disproportionate. It did not find Dr Dharmasena’s behaviour to be fundamentally incompatible with continued registration and considered that Dr Dharmasena can in time develop sufficient insight and remediation.

The Tribunal has determined to suspend Dr Dharmasena’s registration for a period of six months. It is of the view that this period of time is sufficient to satisfy the public interest concerns and would also allow Dr Dharmasena time to develop sufficient insight into his misconduct through further learning and reflection in relation to the prescribing of opiates, online prescribing and the issues of polypharmacy.

**Review hearing directed**

The Tribunal determined to direct a review of Dr Dharmasena’s case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Dharmasena to demonstrate how he has developed sufficient insight and fully remediated his misconduct. It considered that a future Tribunal reviewing this matter would be assisted by:
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- A further reflective statement, to address the deficiencies identified by the Tribunal. Dr Dharmasena should detail how he has developed insight into his misconduct and how that would inform his practice in relation to the prescribing of opiates, online prescribing and the issues of poly-pharmacy.
- Ongoing CPD with written reflections on the learning undertaken;
- Dr Dharmasena will also be able to provide any other information that he considers will assist.

Determination on Immediate Order - 18/07/2019

1. Having determined to suspend Dr Dharmasena’s registration for six months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Dharmasena’s registration should be subject to an immediate order.

GMC Submissions

2. Mr Sastry submitted that an immediate order was necessary to protect public confidence in the profession and patient safety given the risk of repetition identified by the Tribunal.

Submissions on Dr Dharmasena’s behalf

3. Mr Connolly explained that Dr Dharmasena is currently working with the Acute Response Team. He stated that there would have to be good reason to impose an immediate order.

4. Mr Connolly referred to the Tribunal’s determination on sanction, which recognised the content of the testimonials, the continuing work that has been done by Dr Dharmasena to remediate and his potential to succeed in doing so. Mr Connolly stated that the risks related to Dr Dharmasena’s work at White Pharmacy, which was some two years ago.

5. Mr Connolly stated that the Tribunal had found that conditions would have been workable but were insufficient to uphold public confidence. He submitted that this was not due to a perception of an immediate risk in Dr Dharmasena’s current workplace.

6. Mr Connolly confirmed that the Acute Response Team was aware of these proceedings and that they had close oversight over his work on a daily basis. He submitted that the practical result of the imposition of an immediate order would be that the burden would be placed on other practitioners. Mr Connolly stated that the absence of an immediate order would allow arrangements to take place.

7. Mr Connolly confirmed that there was an interim order in place on Dr Dharmasena’s registration.
The Tribunal’s Determination

8. In making its decision the Tribunal exercised its own judgement. It had regard to paragraph 172 of the SG, which states:

"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..."

9. The Tribunal has identified that there is a risk of repetition and, given that risk, it would be inappropriate for there to be no restrictions on Dr Dharmasena’s registration during the appeal period. Additionally, public confidence in the medical profession could be undermined if the Tribunal allowed Dr Dharmasena to practise unrestricted in that period.

10. The Tribunal noted Mr Connolly’s submissions in relation to the practicalities of Dr Dharmasena’s work with the Acute Response Team but was reminded of paragraph 175 of the SG that:

"In considering this argument, the tribunal will need to bear in mind that any doctor whose case is considered by a medical practitioners tribunal will have been aware of the date of the hearing for some time and consequently of the risk of an order being imposed. The doctor will therefore have had time to make arrangements for the care of patients before the hearing, should the need arise.”

11. The Tribunal therefore determined to impose an immediate order of suspension on Dr Dharmasena’s registration.

12. This means that Dr Dharmasena’s registration will be suspended from today. The substantive direction, as already announced, will take effect 28 days from today, 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.

13. The interim order currently imposed on Dr Dharmasena’s registration will be revoked with immediate effect.

14. That concludes this case.

Confirmed
Date 18 July 2019
Mr Sean Ell, Chair
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ANNEX A - 24/06/2019

Application for adjournment and severance

1. At the commencement of the hearing Mr Henry, Counsel on Dr Dharmasena’s behalf, made an application for adjournment of the case and for severance of this matter from Dr Pooley’s case.

2. A written application by the General Medical Council (GMC) for joinder of Dr Dharmasena’s case with Dr Pooley’s case was granted by virtue of an MPTS Case Management decision dated 5 December 2018.

Submissions on Dr Dharmasena’s behalf

3. Mr Henry stated that he was only instructed to make this application, having been instructed at the end of last week. He had other professional commitments such that he could not represent Dr Dharmasena for the four week listing of this case.

4. Mr Henry stated that the Allegation had been sent out on 11 May 2018 and this case was listed for today’s date on 12 February 2019. He stated that Dr Dharmasena made enquiries with a possible legal representative in January 2019 but that on 10 June 2019 they declined to represent Dr Dharmasena. Mr Henry said that Dr Dharmasena then went to Mr Williams, BMA Law, to seek legal representation. Mr Williams understood on 19 June 2019 that the full hearing would start on 24 June 2019 and so an application for postponement was made to the MPTS Case Manager. This application was refused.

5. Mr Henry submitted that enquiries have been made to seek Counsel to represent Dr Dharmasena at this hearing but, given the late instructions, no one was available because of the four week listing of this case.

6. Mr Henry made an application for severance of Dr Dharmasena’s case from Dr Pooley’s case and to adjourn Dr Dharmasena’s case. He submitted that this would ensure that Dr Dharmasena could work with his legal team on preparing a case and so that Dr Dharmasena could be represented at any forthcoming hearing.

7. Mr Henry noted that Dr Dharmasena had been dealing with instructing legal representation earlier in the proceedings, where he had instructed a barrister via direct access. Mr Henry stated that Dr Dharmasena has had some legal assistance in the past via his employers but that a conflict of interest arose.

8. Mr Henry submitted that Dr Dharmasena has received correspondence in relation to his case but that there appeared to be some confusion in relation to a personal email address that was changed. Mr Henry stated that Dr Dharmasena did
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not get back in touch with the GMC or his solicitors but instead had been trying to
develop his insight, which was a mistake. Mr Henry submitted that Dr Dharmasena
should have kept himself informed about when this hearing was listed and cut his
losses earlier with the previous legal representatives.

9. Mr Henry submitted that there was an interests of justice question, given that
Dr Dharmasena would need help when questioning the expert witness. He also
referred to Dr Pooley, who is legally represented, and said that the Tribunal would
need to ensure that Dr Dharmasena has enough time in the process to allow him to
formulate his responses. Mr Henry submitted that the Tribunal would have to
balance the interests of justice in this case, including that Dr Dharmasena would be
unrepresented and not be in a position to proceed immediately, and any possible
injustice to Dr Pooley.

10. Mr Henry submitted that he had tried to find some alternative option but that
he could not find another workable option. He submitted that Dr Dharmasena’s case
should be severed from Dr Pooley’s case, that Dr Dharmasena’s case should be
adjourned and that Dr Pooley’s case should proceed today.

GMC Submissions

11. Mr Sastry, Counsel on behalf of the GMC, submitted that the request for
postponement of Dr Dharmasena’s case had been opposed and that this remained
the position in relation to adjournment. He submitted that Dr Dharmasena has had a
great deal of time to instruct legal representation.

12. Mr Sastry stated that the GMC wants the case to proceed smoothly and in a
way that ensures fairness to both parties. He noted that there were a number of
issues and that the Tribunal should be conscious of the interests of justice in matters
proceeding in a timely fashion.

13. Mr Sastry referred to the previous case management meetings and decisions
that had been made. He stated that Dr Dharmasena had opposed the application for
joinder of the two cases, whilst Dr Pooley’s legal representatives had been neutral
on the point. Mr Sastry stated that Dr Dharmasena did not attend the two
pre-hearing meetings that took place by telephone with the MPTS Case Management
Team in February and April 2019.

Submissions on Dr Pooley’s behalf

14. Given the current joined nature of the case, the Tribunal had regard to the
submissions from Mr Colman, Counsel on behalf of Dr Pooley. Mr Colman confirmed
that they were ready to proceed with the case today. He submitted that it would be
wrong, and not in the interests of justice, if Dr Pooley’s case was postponed.
Mr Colman stated that he had no grounds to object to the application for severance.
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He submitted that, given Mr Henry’s submissions, he had serious concerns about Dr Dharmasena being unrepresented and the future progress of the case. Mr Colman stated that they knew nothing of any legal representative on Dr Dharmasena’s behalf until the middle of the previous week and expressed concerns that Dr Dharmasena’s lack of preparation could disrupt the presentation of Dr Pooley’s case. Mr Colman also said that there were no joint paragraphs of the Allegation, that he has not seen Dr Dharmasena’s papers, and Dr Dharmasena has not seen the hearing papers in relation to Dr Pooley.

The Relevant Legal Principles

15. The Legal Assessor advised that there is no specific Rule in the GMC (Fitness to Practise Rules) 2004 as amended (‘the Rules’) in relation to severance of two cases. He referred to Rule 32 of the Rules in relation to the ‘Joinder’ of cases where a Tribunal may consider and determine together allegations against two or more practitioners “where it would be just to do so”.

16. The Legal Assessor referred to a principle within the Criminal Procedure Rules that might be of some assistance, namely Rule 3.21(4) where separate trials may be conducted if for any reason it is desirable that the defendants are tried separately. He stated that ‘desirable’ could support the suggestion that severance would be appropriate “where it would be just to do so”.

17. The Tribunal had regard to paragraph 29(2) of the Rules, in relation to adjournment:

“Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.”

18. The Legal Assessor referred the Tribunal to the case of R v Jones [2002] UKHL 5, as to a number of facts to consider in relation to adjournment. These included consideration of the likely length of any adjournment including the length of Dr Dharmasena’s case in the future should it be adjourned today, whether Dr Dharmasena wishes to be represented at a future hearing, the impact on any witnesses and, given the joinder aspect, the prospects of a fair hearing for those who are joined with this case.

Tribunal’s Decision

19. The Tribunal considered whether Dr Dharmasena’s case should be adjourned and severed from Dr Pooley’s case.
20. The Tribunal was mindful that Dr Dharmasena had been legally represented in 2017, earlier in the proceedings, and was informed of the allegations against him in May 2018. Dr Dharmasena tried to instruct legal representation in January 2019. The Tribunal noted that Dr Dharmasena would have been receiving information from the GMC and MPTS and that he failed to contact his legal representatives to check the position during this time, with matters left until shortly before this hearing. The Tribunal found this to be a clear delay in Dr Dharmasena pursuing legal representation, a matter which was for his consideration alone.

21. The Tribunal had regard to the reasons why the ‘Joinder’ application was granted in December 2018, including that:

"Dr Dharmasena will have the opportunity to explain to the Tribunal what he perceives the differences in practice to be and the impact they ought to have on the Tribunal’s assessment of the care provided. As regards the second issue, Dr Dharmasena will have the opportunity to challenge the GMC’s expert evidence through cross-examination, and the opportunity to do so will not be reduced by the allegations being joined to be aired in front of a single Tribunal.”

22. The Tribunal considered whether there would be unfairness to Dr Pooley if Dr Dharmasena’s case remained joined. The Tribunal noted that the two doctors are not charged with the same allegations but that they did operate under the same system and there are some patients where the matters overlap. It was also mindful that the case management documentation appears to suggest that Dr Dharmasena wishes to challenge some of the GMC expert witness evidence. The Tribunal will look at each paragraph of the Allegation separately in relation to each doctor and both will have opportunity to present their case and ask questions of the GMC expert witness should they wish to do so. The Tribunal concluded it would not be unjust to either Dr Dharmasena or Dr Pooley for the cases to remain joined.

23. Dr Pooley is ready for matters to proceed. The Tribunal was conscious that Dr Dharmasena may require more time during the hearing given that he may be unrepresented but the Tribunal determined that appropriate adjustments can be put in place to ensure fairness to all and for the hearing to proceed in a timely manner.

24. The Tribunal felt that Dr Dharmasena has had more than sufficient time to arrange legal representation for the hearing and that, because of his own inaction, he has found himself in his current position. The Tribunal took account of its decision that the hearing should not be severed and that, as such, a decision to adjourn would have the inevitable consequence of Dr Pooley’s hearing also having to be adjourned. The Tribunal determined that it would not be fair to do so. The Tribunal concluded that it would not be unfair for Dr Dharmasena’s hearing to proceed, notwithstanding that he might not be legally represented.
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25. In all the circumstances, the Tribunal refused Mr Henry’s application for adjournment of Dr Dharmasena’s case and for severance from Dr Pooley’s case.

ANNEX B - 24/06/2019

Application for adjournment

1. Following the original application for adjournment, Mr Henry confirmed that he had only been instructed in respect of that application. Dr Dharmasena was present but not represented after this point. Dr Dharmasena made an application for adjournment of the case for one or two days to allow him to prepare his case.

Dr Dharmasena’s Submissions

2. Dr Dharmasena asked the Tribunal for one or two days to prepare his case in order for him to go through the patient notes and confirm which paragraphs of the Allegation he could make admissions to, if any.

3. Following a question from the Tribunal, Dr Dharmasena stated that he should hopefully be able to prepare his questions for the GMC expert witness too.

4. Dr Dharmasena said that he did not have his copies of the hearing papers with him, which were at his house some five hours drive away.

GMC Submissions

5. Mr Sastry referred the Tribunal to the time that Dr Dharmasena has already had to prepare his case. He stated that the GMC has concerns about the timetable of the case and confirmed that he was instructed to object to any further adjournment. Mr Sastry acknowledged that the process of Dr Dharmasena considering which admissions could be made might save some time.

6. Mr Sastry provided details of the availability of the GMC expert witness. He stated that the expert was discussing matters with Dr Pooley’s expert witness and that he would be able to open the case on 25 June 2019, but not before.

Submissions on Dr Pooley’s behalf

7. Mr Colman provided details of the availability of Dr Pooley’s expert witness, Dr N. He stated that there were limited areas of dispute between Dr N and the GMC expert witness.

The Relevant Legal Principles
8. The Tribunal again had regard to paragraph 29(2) of the Rules. It noted that it should take into account the need to ensure a fair hearing for all three parties involved and bearing in mind the public interest. The Tribunal noted that there were a number of aspects to consider including the case management directions made and that all parties should be able to present their case properly.

**Tribunal’s Decision**

9. The Tribunal had regard to the reasons for adjournment given by Dr Dharmasena. It was mindful that Dr Dharmasena would use the time to prepare his case in relation to the admissions he might make and the questions he might have of the GMC expert witness. The Tribunal was of the view that this would help clarify matters and progress the case in a structured manner, which would help avoid repetition or unnecessary discussion. The Tribunal was also conscious of a number of practical issues including Dr Dharmasena’s lack of paperwork at the hearing and his travel difficulties and therefore whether it would be unfair to proceed without adjourning. The Tribunal determined that a short adjournment would not be unfair to the other parties.

10. The Tribunal determined to grant Dr Dharmasena’s application for additional time. It adjourned the hearing for one day, to reconvene at 9.30am on Wednesday 26 June 2019.
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### Schedule One

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Record of Determinations –
Medical Practitioners Tribunal

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Schedule Two

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