**General Pharmaceutical Council**

**Fitness to Practise Committee**

**Principal Hearing**

**3-9 May 2022**

**In person and in public**

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| **Registrant name:** | Munawar Iqbal |
| **Registration number:** | 2059871 |
| **Part of the register:** | Pharmacist |
| **Type of Case:** | Misconduct |
| **Committee Members:** | Manuela Grayson (Chair)<br>Raj Parekh (Registrant member)<br>Sara Atkins (Lay member) |
| **Secretary:** | Zainab Mohammed |
| **Registrant:** | Attended |
| **Registrant's Representative:** | Kevin McCartney, Counsel, instructed by Noel Wardle of Temple Bright |
| **General Pharmaceutical Council:** | Represented by Matthew Corrie, Counsel |
| **Facts proved:** | 1, 2, 3, 3.1 ,3.2, 3.3. |
| **Fitness to practise:** | Impaired |
| **Outcome:** | Suspension (4 months) with a review before expiry |
| **Interim measures:** | Interim suspension |

This decision including any finding of facts, impairment and sanction is an appealable decision under our rules. Therefore, this decision will not take effect until 8 June 2022 or if an appeal is lodged once that appeal has been concluded. However, the interim suspension set out in the decision takes effect immediately and will lapse when the decision takes effect or once any appeal is concluded

## Introduction

1. This Principal Hearing relates to Mr Munawar Iqbal ["the Registrant"], a pharmacist first registered with the Royal Pharmaceutical Society of Great Britain on 26 October 2004 and subsequently registered with the General Pharmaceutical Council ["the Council"]. The Registrant's registration number is 2059871. He has been qualified as a Pharmacist Independent prescriber ("PIP") since 2012.

2. This matter is governed by the Pharmacy Order 2010 ["the Order"] and the General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010 ["the Rules"].

3. The Notice of Hearing listing the matter before the Fitness to Practise Committee was sent to the Registrant's registered email on 22 March 2022.

4. The Council was represented by Mr Matthew Corrie of Counsel. The Registrant attended and was represented by Mr Kevin McCartney of Counsel, instructed by Mr Noel Wardle of Temple Bright.

## Application to amend the Allegation

5. Mr Corrie, on behalf of the Council, made an application pursuant to Rule 41 of the General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules Order of Council 2010 ("the Rules") to amend allegations 3.1 and 3.2 as set out below, on the basis that the proposed amendments narrow the scope of the Council's case and so cause no prejudice to the Registrant, and nor, he submitted would the allegations as amended cause prejudice to the wider public interest either.

*"3.1. You failed to carry out ~~any, or any~~ adequate~~,~~ checks as to whether the medication was suitable to be prescribed to the patient; and/or*

*3.2. You failed to carry out ~~any, or any~~ adequate~~,~~ checks as to whether the patient's medication use would be monitored and/or reviewed by another healthcare professional".*

6. Mr McCartney did not object to the application.

7. Rule 41 provides that:

*"(1) At a principal hearing, at any stage before making its findings of fact, the Committee may of its own motion or following an application of one of the parties, amend the particulars of the allegation set out in the Notice of Hearing, unless it is of the view that the required amendment would prejudice the fairness of the proceedings."*

8. The Committee considered the application in the light of all of the evidence before it and the provisions of Rule 41. It was of the view that the proposed amendment would cause no prejudice to the Registrant because it correctly set out the alleged mischief and did not extend or increase the gravity of the allegations, and neither did the Committee consider that the proposed amendments would prejudice the wider public interest in that all of the matters raised in the particulars remained to be considered, save that the amendments allowed for the Registrant's case that he had made some checks in relation to the medications he had allegedly prescribed. The Committee therefore granted Mr Corrie's application and amended the Allegation accordingly.

**The Allegation, as amended**

9. The Registrant faced the following Allegation:

*"You, a registered pharmacist independent prescriber, with registration number 2059871:*

*1. Prescribed medication when it was inappropriate to do so in that the medication was for animals including those as set out in Schedule A.*

*2. Did not have lawful authority to prescribe as set out at 1 above.*

*3. Issued the prescriptions set out in Schedule B:*

*3.1. You failed to carry out adequate checks as to whether the medication was suitable to be prescribed to the patient; and/or*

*3.2. You failed to carry out adequate checks as to whether the patient's medication use would be monitored and/or reviewed by another healthcare professional;*
*3.3. You acted outside the scope of your practice and/or competency.*

*By reason of the matters set out above your fitness to practise is impaired by reason of misconduct".*

Schedule A contained a list of 25 alleged prescriptions issued for animals between June and July 2019; and Schedule B contained a list of 90 prescriptions allegedly issued for humans between June and July 2019.

**BACKGROUND**

10. Mr Corrie, in the Council's Statement of Case and Skeleton Argument, provided a helpful summary of the background to this case as set out in the Witness Statements of Inspector 1 and Inspector 2, to which no objections were raised on the Registrant's behalf. The information below relies on the Council's summary.

11. The Pharmacy was a normal bricks and mortar pharmacy which provided community pharmacy services during the day time but there was also a night operation of an online pharmacy service. On 15 May 2019 the inspection was in relation to the community pharmacy services. On 31 May 2019, Inspector 1 attended the Pharmacy a second time and spoke to the Superintendent ("SI") pharmacist, Mr 3, in relation to the operation of the online pharmacy services. Inspector 1 gives evidence that the SI told her that the Pharmacy's online service operated at night and states that the SI then printed a copy of an overseas prescription along with a UK prescription for the same patient and medication along with duplicated medication and delivery labels. The Registrant was the UK prescriber who was issuing the prescriptions.

12. Inspector 1 states that she has never met the Registrant and that he was not present at the inspection. She describes the prescriptions produced by the Registrant as appearing to be copies of the overseas prescriptions, transcribed and signed by him.

13. Inspector 1 wrote an inspection report following on from the inspections. The report set out that the online business was generated via a website, www.medixpharmacy.co.uk,

whereby a company called Medimart Ltd ("Medimart") provided foreign prescriptions and other documents via an online portal. The Registrant, as a UK based PIP, produced UK prescriptions which were sent to the Pharmacy by post.

14. Inspector 1 attended the Pharmacy a third time on 9 July 2019, on this occasion she was accompanied by Inspector 2, Senior Clinical Pharmacy Advisor and Specialist Inspector at the GPhC.

15. On this occasion Inspector 1 seized a copy of the prescriptions issued by the Pharmacy and the prescription record for the whole of June 2019 and 1 - 7 July 2019.

16. Inspector 1 states that the Registrant was issuing about 7,000 prescriptions per month.

17. Inspector 2 set out in her Witness Statement that the Registrant was not present when she attended the Pharmacy on 9 July 2019, but Inspector 2 was able to speak to him by telephone. Her account is that he told her that he used a portal to obtain overseas prescriptions from another company and that he then wrote them as private prescriptions which can then be dispensed in the UK. He said that he would send the prescriptions to the Pharmacy. Inspector 2 states that the Registrant told her that he could request access to patients' medical records, bloods and other information.

18. She also recalls that the Registrant told her that he was not prescribing independently but was "co-prescribing" the medication. Further, he said that within the agreement with the company from which he obtained the prescriptions, the onus for conducting checks and clinical assessments was on the original overseas prescriber. Inspector 2's notes of the call record that the Registrant told her he was not initiating the prescriptions but was "co-signing" them and that he did not bear sole responsibility according to his contract with Medimart.

**Service level Agreement**

19. There was a Service Level Agreement ("SLA") between Medimart and MDX Healthcare Ltd signed by the Superintendent of the Pharmacy for the provision of pharmacy fulfilment services. Within the SLA (amongst other clauses) it was agreed that Medimart would

provide customer order information via a secure online order system and that it would verify the accuracy of all information provided to the Pharmacy. The Pharmacy agreed (among other matters) to perform its services with due care and skill and in accordance with the relevant rules and laws which applied.

20. Further, the Pharmacy was required to provide the medication to the delivery agent within two days of receipt of the order or to notify Medimart if this was not possible.

21. Schedule 1 to the SLA, titled Statement of Work sets out that Medimart Ltd will perform a number of services including:

- Patient identity checks;
- Physician/prescriber veracity checks;
- Monitoring checks.

**Clinician Services Agreement**

22. The Clinician Services Agreement ("CSA") between the Registrant and Medimart dated 11 July 2018 set out that he was provided with foreign prescriptions and patient information against which he issued the prescriptions in the UK.

23. The background section of the agreement sets out that:

*(A) "Medimart operates as a business services provider for an online pharmacy, hosted at www.medixpharmacy.co.uk (the "Site"), and acts as an agent for its Patients in order to assist Patients in obtaining cost effective prescription medication ordered via the Site.*

*(B) Medimart requires the Patient's prescription relating to each order to be reviewed and cosigned where appropriate by the clinician. For the benefit of co-signing, a copy of the Original Physician's prescription will be made available for viewing using proprietary software which will be Internet Protocol ("IP") locked to the clinician's verified IP address. In addition, other patient relevant information will be made available including, but not limited to, the Patient's date of birth, age, other relevant history. For avoidance of doubt,*

*patients are not able to place orders, unless there is receipt of the original prescription issued by the authorised physician.*

*(C) The Clinician is willing to complete Verification for Patients referred by to the Clinician and provide, where appropriate, the Prescription (all as defined below)."*

24. Within the CSA is set out that the Registrant will provide the services set out in Schedule 1, as follows:

*"1. At the request of Medimart and upon receipt of a Patient Order, the Clinician shall review the information provided and assess the authenticity, accuracy and appropriateness of the proposed medicine and otherwise exercise and carry out the Clinician's professional diligence, including, if appropriate, contacting the Patient and/or their Physician (the "Verification"). Each Verification relates to an individual patient and may involve one or more medications.*

*2.Medimart will provide the following pre-clinical services as part of the Clinicians Safe Guarding Policy and in order to assist in Clinician's co-signing activities:*

- *Medimart employed clinical pharmacists ("Medimart Pharmacists") specialised in United States medical practice will ensure that the original prescription from the patient is in receipt before an order is submitted for co-signing.*
- *All original prescriptions are clinically checked by Medimart Pharmacists.*
- *Relevant / updated Blood Test Reports will be confirmed to have already been assessed by patients lead physician at Doctors office for certain medications which require therapeutic monitoring.*
- *Medimart Pharmacists will be available at any time for telephonic communication to assist in queries that the clinician may have.*

*3. Once the Clinician has completed the Verification, the Clinician shall, if appropriate in its professional judgment, write the Prescription for the Patient and provide the Prescription to Medimart (generating a script to Medix Pharmacy) including details of the type of drug, strength of drug, directions for use and number of refills. If the Clinician is unable to complete the Verification and provide a Prescription for any medicines contained in Patient Order on the basis that a proposed medicine is not*

*appropriate for the Patient, the Clinician shall notify Medimart and explain in detail why the Verification has not been completed ("Rejection Notice").*

*4. The Clinician shall use reasonable endeavours to complete the Verification and provide the Prescription (and/or where appropriate a Rejection Notice) to Medimart within 3 hours of receipt of a Patient Order received between the hours of 8:30 to 17:30 on any day (including weekends and bank holidays in England), and in any event no later than within 1 day of receipt of a Patient Order.*

*5. If the Clinician is unable to complete the Verification and provide the Prescription (and/or where appropriate a Rejection Notice) to Medimart within 1 day of receipt of a Patient Order, then the Clinician agrees to immediately notify Medimart and explain in detail why the Prescription (and/or where appropriate a Rejection Notice) has not been completed."*

25. Further, within the main clinician agreement at clause 3.22, the Registrant agreed to "*observe all prescribing regulations, health and safety rules and regulations and any other applicable law, regulation or code of practice relating to the Services."*

26. Additionally, at clauses 5.1.3 – 5.1.6 the Registrant warranted that he:

*"5.1.3 shall perform the Services with all due skill and care and in accordance with generally recognised practices and professional standards in the pharmacy profession for similar services and within the Clinician's clinical competence;*

*5.1.4 will complete each Verification in good faith and will not provide Medimart with a Prescription until after a complete and accurate Verification has been completed;*

*5.1.5 will ensure that the Services conform in all respects and at all times with any specification or description for the Services agreed by the parties and comply with all applicable legislation; and*

*5.1.6 will meet any agreed performance dates, including the service levels set out in Schedule 1, and time for performance by the Clinician shall be of the essence of this Agreement."*

27. Mr Corrie, in the Council's Statement of Case and Skeleton Argument, summarised the

arrangement as follows:

*"Thus the arrangement was that the Registrant would be provided with foreign prescriptions and additional information about the patient and he was contracted to review the information available to him and to, if appropriate, issue the prescriptions. In carrying out this role the agreement required him to exercise due care and skill and to act within the requirements of the law. The Registrant was required to carry out the verification and to issue a prescription within a day and if unable to do so was required to provide an explanation.*

*In return, Medimart agreed to provide the foreign prescription and relevant patient information, carry out their own clinical checks, assessment of blood tests for the purposes of clinical monitoring".*

28. The Registrant was paid £1000 per month for his services, with no upper limit on the number of verifications he processed and prescriptions he issued.

**Documentation before the Committee**

29. Prior to the hearing, the Committee was provided with the following documentation:
    - Council's 37 page Statement of Case and Skeleton Argument;
    - Council's bundle including witness statements and exhibits (743 pages). These included: Witness Statement of Inspector 1, Pharmacist Inspector for the Council, together with exhibits including her detailed Investigation Report for the Pharmacy, prescriptions, Responsible Pharmacist log for night time service on relevant dates, email exchanges; Witness Statement of Inspector 2, then Chief Pharmaceutical Officer's Clinical Fellow for the Council, with exhibits, including prescriptions and various professional guidance and formularies; Production Statement of AP which exhibited the Service Level Agreement between Medimart Ltd and MDX Healthcare Ltd, and the Clinical Services Agreement between the Registrant and Medimart Ltd; and an Expert Report from Pharmacist Mr 4, a Pharmacist Independent Prescriber with extensive experience of acting as an expert witness, together with exhibits, as well as an additional bundle of references referred to by expert Mr 4, of 1638 pages.

- Registrant's Bundle of 73 pages which included the Registrant's 12 page Witness Statement signed and dated 10 April 2022, and exhibits including certificates of training and seven positive testimonials from professional colleagues, all of whom confirmed that they were aware of the allegations faced by the Registrant.

**Admissions**

30. At the start of the hearing, Mr McCartney, on behalf of the Registrant, admitted particulars 1 to 3 of the Allegation in their entirety.

**The Committee's determination on the Facts Alleged**

31. In accordance with Rule 31(6) of the Rules, the Chair announced that the facts alleged at particulars 1 to 3 of the Allegation, were found proved.

32. The Committee took into account, in accepting the admissions of the Registrant, all of the prescriptions contained within the Council's bundle. It also took into account the admissions made by the Registrant in his Witness Statement dated 10 April 2022. With regard to particulars 1 and 2, the Registrant confirmed in his Witness Statement that he was not authorised to prescribe medication for animals, but he said he had assumed at the time that he was so authorised. As for particular 3, the Registrant admitted that, although he entered into the relationship with Medimart in good faith, he relied too much on local prescribers' clinical judgement and could not be sure his own prescribing was safe; he admitted that although he did make some clinical checks, his own checks were not adequate and he also admitted that he did not have the specialist experience required to prescribe a number of the medications set out in Schedule B.

**Particulars 1 and 2:**

*"You, a registered pharmacist independent prescriber, with registration number 2059871:*

*1. Prescribed medication when it was inappropriate to do so in that the medication was for animals including those as set out in Schedule A.*

*2. Did not have lawful authority to prescribe as set out at 1 above.*

33. In relation to particulars 1 and 2, in addition to accepting the Registrant's admissions, the Committee had regard to the relevant evidence. This included the list of prescriptions for medication in Schedule A, which were for animals including dogs, cats and a parrot. There were instances in which a human medication was prescribed for an animal and also cases where Prescription Only Medicine Veterinarian ("POM-V") medication was prescribed for animal. The evidence of Inspector 2 was that human licensed medication and POM-V medications can only legally be prescribed for an animal by a Vet registered with the Royal College of Veterinary Surgeons.

**Particulars 3, 3.1 and 3.2:**

*3. Issued the prescriptions set out in Schedule B:*
*3.1. You failed to carry out adequate checks as to whether the medication was suitable to be prescribed to the patient; and/or*
*3.2. You failed to carry out adequate checks as to whether the patient's medication use would be monitored and/or reviewed by another healthcare professional;*

34. In relation to the stem of particular 3, the Committee, in addition to accepting the Registrant's admissions, also took into account the list of prescriptions set out in Schedule B.

35. Particulars 3.1 and 3.2 in essence alleged failure to practise adequately as an independent prescriber. In considering these particulars, the Committee took into account the admissions of the Registrant as set out in his Witness Statement. He stated:

"*[L]ooking back, I think that (subconsciously) I avoided raising too many queries because I was worried that it might jeopardise my position with Medimart. I therefore tended to raise queries more often in relation to the higher risk medication if I did not feel that there was enough information to justify prescribing. Even then, I accept that I did not have all the information that was necessary to prescribe independently for these patients… Whilst I … believe that I had some information available to me to check whether the medication was suitable to be prescribed for the patient and to satisfy myself that the patient was under the care of their primary physician … I accept that this information was not adequate…*,".

36. The Committee also had regard to the Witness Statement of Inspector 2, and the expert opinion of Mr 4. It bore in mind The Royal Pharmaceutical Society Competency Framework which defines independent prescribing as "*prescribing by a practitioner, who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing".*

37. The Committee accepted the Registrant's own description in his Witness Statement of how and to what extent he checked the appropriateness of the prescriptions requested of him by Medimart Ltd, and to what extent if at all, he monitored the patients' use of the medications he prescribed. He admitted that he was never able to contact the patients directly because he was not supplied with their phone numbers; in addition he stated that due to the quantity of prescriptions he was required to issue, the haste with which he was required to complete prescriptions once requested, and also the fact that he felt that Medimart had led him to believe that he was not permitted to make too many enquiries, he often relied on the clinical judgement of the prescribers outside the UK, rather than ensuring for himself that medication was appropriately prescribed and /or monitored.

38. The Committee also had regard to the Investigation Report prepared by Inspector 1 in which she stated that there were concerns in relation to the nature of the agreement with Medimart, in that Medimart, rather than the Registrant himself, would be responsible for carrying out clinical and monitoring checks.

**Particular 3.3:**

*3.3. You acted outside the scope of your practice and/or competency.*

39. In finding particular 3.3 proved, the Committee accepted the Registrant's admissions, as set out in his response and summarised below:

*In relation to my clinical competency to prescribe for the patients listed in the Particulars of Allegation, whilst I did have some competency to prescribe in some of these areas (from my own clinical knowledge, the prescriptions from the patients' treating physician and the*

*information available to me from Medimart), I accept that I did not have either sufficient or specialist clinical competency as described in the report of Mr Steven Williams for the patients listed within the schedule to the Particulars of Allegation. I relied too much on the prescriptions from the patient's treating physician rather than making my own checks as to the patient's condition and monitoring and satisfying myself that I had sufficient competency to prescribe for those patients and condition".*

40. The Committee found that the Registrant was not competent as a specialist prescriber in relation to a number of the health conditions (including mental health conditions, paediatric epilepsy, HIV and cancer) for which he nevertheless issued prescriptions. Furthermore, the Committee accepted the evidence before it which demonstrated that he issued numerous prescriptions in quantities and /or strengths which are not appropriate according to UK rules and guidance.

41. The Committee accepted the detailed observations of both Inspector 1 and of Mr 4, in relation to the prescriptions at Schedule B. Together, they set out information regarding the clinical checks and monitoring requirements which would have been required of the Registrant to ensure safe and appropriate practice, and also the witnesses' concerns about the appropriateness and risks connected with the prescriptions listed in the Schedule. The Committee took into account that, based on her review of the sample of prescriptions, Inspector 2 was concerned that the Registrant "was not prescribing safely".

42. A summary of Mr 4's expert evidence, and further evidence from Inspector 2, relevant to the Registrant's standard of practice, are set out at Stage Two of this determination, relating to Grounds and Impairment. However, at this stage, the Committee considers it helpful to quote the conclusion of Mr 4's in relation to the Registrant's standard of prescribing which it has taken into account when determining that the facts alleged at particular 3.3 are proved:

*"It is therefore my opinion, based on the evidence I have seen, that the registrant prescribed indiscriminately, irrationally, and unsafely without the necessary clinical assessment/ checks and suitable monitoring expected within the RPS competency framework, and thus far below their scope of practice and competency as a pharmacist independent prescriber."*

43. For all the above reasons, the Committee found the facts of the Allegation proved in their entirety.

**STAGE TWO: THE IMPAIRMENT STAGE**

1. Having found the facts proved, the Committee went on to consider whether those facts amount to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired by reason of his misconduct.

**Evidence in relation to Misconduct and Impairment**

Particulars 1 and 2:

2. Inspector 2 stated in her Witness Statement that the Registrant had no authority to prescribe the medications set out in Schedule A because he is not a vet. The Registrant's evidence was that he thought he was so authorised, but he admitted that he should have checked the relevant guidelines thoroughly but did not do so.

Particular 3:

3. The Witness Statements of Inspector A and Mr 4 contained detailed analysis of the prescriptions in Schedule B. Both witnesses set out their knowledge and opinions as to the clinical checks and, where relevant, monitoring, which would be expected for safe and effective prescribing of the medications listed. They described their concerns in relation to the evidence of the Registrant's standard of practice, as demonstrated by the evidence of his online prescribing which was obtained during the Council's investigation.

Evidence of Mr 4

4. The evidence of Mr 4 is summarised below (the tables are taken from the Council's Statement of Case, prepared by Mr Corrie):

Children under 12 years old

5. Schedule B contained prescriptions for two children of medications used for the treatment of epilepsy. Patient 1 was a four-year-old child based in India and was prescribed by the Registrant 180 200 mg tablets of Inovelon (Rufenamide). Patient 2 was a seven year old based in Romania and was prescribed by the Registrant 300 powder for oral solution 500 mg Sabril (Vigabatrin).

6. Mr 4 stated that prescribing for epilepsy is a highly specialised area, more so in paediatrics, which requires competency in both fields. Further he stated that both patients are based in countries where the healthcare access and opportunity for review is likely unknown. He described the risk as being of under dosing, especially as the child gets heavier and that if the dose is not reviewed and adjusted this could be an ineffective treatment choice. At worst this could lead to frequent uncontrollable seizures resulting in neurological deficit or even fatality.

7. Thus, his view is that in order for the prescribing to have been satisfactory the Registrant would have had to be competent in both areas and have been satisfied appropriate reviews were being carried out.

Patients aged over 80

8. Mr 4 stated that prescribing for older patients should be done carefully and medicines reviewed regularly as the balance of risks and benefits alters as patients get older. This is due to them often receiving multiple medications and age associated physiological, functional, and cognitive changes increasing the risks of adverse side effects.

9. Patient 4 was an 89 old year female who was prescribed by the Registrant 84 0.625mg tablets of Premarin which is a hormone replacement therapy ("HRT"). Mr 4 explained that HRT typically would have a maximum duration of ten years post menopause otherwise there is an increased risk of breast and ovarian cancer, heart disease, stroke and venous thromboembolism. Further, a prescriber would need to know whether the patient has a uterus or not as this impacts the type of oestrogen required. He also points out that prescribing HRT is a specialised area and is highly specialised when prescribing for patients beyond their sixties.

10. Patient 5 was an 80-year-old female for whom the Registrant prescribed 48 2.5mg Naratriptan Hydrochloride tablets. This medication is used for the treatment of migraines and Mr 4 states that it is contraindicated for patients with a history of stroke and so a prescriber would need to know whether the patient had a history of stroke before prescribing this medication.

11. Patient 6 was an 86 year old male who was prescribed by the Registrant 84 24/26mg Entresto tablets. The medication is described by Mr 4 as a specialist heart failure medication which requires careful dose titration to maximise the benefit and to minimise the risk of overtreatment and cardiovascular complications such as low blood pressure. Mr 4 says that this is a specialised area of treatment, especially for patients over sixty and a competency in this field would be required to prescribe it.

Medications with a narrow therapeutic index

12. Mr 4 explained that a narrow therapeutic index is:

"*when the ratio between the lowest concentration associated with toxicity and the lowest concentration associated with benefit is low. This means that the concentration range over which the drug is both safe and effective is narrow: there is little 'safety margin' before toxicity supervenes."*

13. Mr 4 identified a number of prescriptions for medications with a narrow therapeutic index, which include the following:

| **Patient number** | **Prescription, indication & comment** | **bundle Page number of prescription** |
|---|---|---|
| Patient 7 | 200 500mg tablets of Mycophenolate Mofetil, two tablets every twelve hours.<br><br>Mr 4 comments that this medication is an immunosuppressant which required blood count monitoring at least every twelve weeks and that this was a hundred days of medication. | 659 |
| Patient 8 | 100 2.5mg tablets of Methotrexate.<br>Mr 4 states that this is a cytotoxic immunosuppressant which requires monitoring of blood counts and liver function at least every twelve weeks. | 660 |

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| Patient 9 | As above. | 661 |
| Patient 10 | As above. | 662 |
| Patient 11 | As above. | 663 |
| Patient 12 | As above. | 664 |
| Patient 13 | As above. | 665 |
| Patient 14 | As above. | 666 |
| Patient 15 | As above. | 667 |
| Patient 16 | As above. | 668 |
| Patient 17 | As above. | 669 |
| Patient 18 | As above. | 670 |
| Patient 19 | As above. | 671 |
| Patient 20 | As above. | 672 |
| Patient 21 | As above. | 673 |
| Patient 22 | As above. | 674 |
| Patient 23 | As above. | 675 |
| Patient 24 | As above. | 676 |
| Patient 25 | As above. | 677 |
| Patient 26 | 280 50mg tablets of Azathioprine 1 tablet three times daily.<br>Mr 4 explains that this medication is a cytotoxic immunosuppressant which requires monitoring of blood counts and liver function at least every twelve weeks. | 678 |
| Patient 27 | 200 Imuran (Azathioprine) 50mg tablets and 200 60mg Mestinon (pyridostigmine) tablets.<br>As above. | 679 |
| Patient 28 | 90 1 mg tablets of Rapamune (Sirolimus) one a day. | 680 |

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| | Mr 4 explains that this medication is an immunosuppressant which requires monitoring of blood counts at least every twelve weeks. | |
| Patient 29 | 10 50mg/0.5ml Myocrisin injections one to be used every 3 -4 weeks as directed.<br>Mr 4 states that this medication is an immunosuppressant which requires monitoring of blood counts at least every twelve weeks. | 681 |
| Patient 30 | 84 25mg Valdoxan (agomelatine) tablets one tablet twice daily.<br>Mr 4 states that this is a specialist mental health drug which requires monitoring | 682 |
| Patient 31 | 30 5mg/0.4ml Arixtra (Fondaparinux) injections.<br>Mr 4 states that this medication is an anticoagulant injection which requires monitoring of bodyweight, renal function and blood count to assess if the dose is appropriate every twelve weeks. | 683 |
| Patient 32 | 85 100mg tablets of Amiodarone Hydrochloride one tablet daily.<br>Mr 4 states that this is a toxic cardiac medication which requires monitoring of liver and thyroid function every twelve weeks and an annual assessment of lung function. | 684 |
| Patient 33 | 56 20mg tablets of Xarelto (Rivaroxinban).<br>Mr 4 states that this is an oral anticoagulant prescribed to an eighty three year old patient which required at least annual confirmation of bodyweight, renal function and blood counts in order to assess the appropriate dose. | 685 |
| Patient 34 | 84 20mg Furosemide tablets prescribed to a ninety four year old male. | 686 |

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|---|---|---|
| | This is a diuretic which Mr 4 states requires monitoring of renal function at least every 26 weeks. | |
| Patient 35 | A prescription for 168 200mg and 168 400mg Tegretol Prolonged Release tablets.<br>Mr 4 says that this is a large dose of an antiepileptic drug which requires at least annual monitoring to ensure adequate treatment and prevent severe neurological toxicity. | 687 |

14. Mr 4 stated that high risk medicines need monitoring for both efficacy and toxicity when first prescribed in order to establish the lowest effective dose with minimal side effects. These medicines may need to be reviewed as regularly as every month dependent upon the patient and the complexity of their health.

15. In relation to Patients 7 – 32, Mr 4 was seriously critical of the standard of care apparently provided by the Registrant, in that prescribing most of these medicines would not be expected to be carried out by a generalist practitioner as they require specialist competencies. He stated that the harms associated with these medicines in untrained hands is potentially fatal.

16. For Patients 33 – 35 Mr 4s' opinion was that these medications could be expected to be prescribed by an experienced generalist prescriber if they had up to date information about a patient's clinical status and blood tests.

<u>Antimicrobials</u>

17. Mr 4 has also identified a number of prescriptions for antimicrobials in respect of which he has identified concerns:

| **Patient number** | **Prescription, indication & comment** | **Bundle Page number of prescription** |
|---|---|---|

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|---|---|---|
| Patient 36 | 30 600/200/300mg tablets of Atripla<br><br>An antiretroviral therapy usually used to treat HIV positive patients | 688 |
| Patient 37 | 180 25mg Vemildy (Tenofir) tablets for a patient in China.<br><br>Mr 4 states that this is usually indicated for treatment of Hepatitis B | 689 |
| Patient 38 | 56 tablets of 550mg Targaxan (rifamixin).<br><br>Mr 4 states that this is usually indicated for hepatic encephalopathy in alcohol dependent patients | 690 |
| Patient 39 | 24 tablets of 20/120mg tablets of Riamet.<br><br>A specialist antimalarial treatment. | 691 |
| Patient 40 | 100 500mg tablets of Ciprofloxacin Hydrochloride<br><br>Mr 4 describes this as a broad spectrum antibiotic with a high chance of antimicrobial resistance. | 692 |
| Patient 41 | 100 100mg tablets of Nitrofurantoin.<br><br>Mr 4 states that with long term use there would be concerns about lung and neurological toxicity without appropriate monitoring. | 693 |
| Patient 42 | 56 200mg capsules of Fluconazole<br><br>A broad spectrum antifungal with a high potential for drug interactions. | 694 |

18. In respect of Patients 36 and 37, Mr 4 is seriously critical of the Registrant's prescribing in that he states that they are highly specialist antiviral and immune suppressant medicines with the potential for drug interactions. He states that they should only ever be

prescribed by a highly specialist prescriber and never by a generalist prescriber.

19. In relation to Patients 38 and 39 Mr 4 states that the prescribing of these medicines would not be expected to be carried out by a generalist prescriber as they require specialist competencies.

20. In regard to Patients 40 – 42 Mr 4 accepts that these could be prescribed by an experienced generalist prescriber provided they had considered the diagnosis, other options to reduce the risk of antimicrobial resistance and if they had up to date information about the patient.

Medications prescribed for specialist conditions

21. Mr 4 sets out a number of prescriptions issued in relation to various specialist conditions such as mental health, diabetes, cancer, Parkinson's disease, and blood conditions:

| **Patient number** | **Prescription, indication & comment** | **Page number of prescription** |
|---|---|---|
| Patient 43 | 100 500mg tablets of Ferriprox (deferiprone)<br><br>This is used in the treatment of the blood condition thalassaemia | 695 |
| Patient 44 | 100 140mg capsules of Estracyt (estramustine) a cytotoxic agent used to treat prostate cancer | 696 |
| Patient 45 | 60 200mcg tablets of Cytotec (misoprostol) | 697 |
| Patient 46 | 90 9.5 mg/24 hr Rivastigmine patches for dementia | 698 |
| Patient 47 | 56 1mg Anastrozole tablets<br>A breast cancer treatment | 699 |
| Patient 48 | 90 500mg tablets of Depakote (Sodium Valproate)<br>Used for bi-polar disorder | 700 |
| Patient 49 | 90 50mg Ongentys capsules for Parkinson's disease | 701 |

| | | |
|---|---|---|
| Patient 50 | 20 20mg Tadalafil tablets | 702 |
| Patient 51 | 84 6mg/24hr Neupro patches<br>A dopamine agonist used for Parkinson's disease and restless legs syndrome | 703 |
| Patient 52 | 90 9.5mg/24 hr Rivastigmine patches & 30 13.3mg/24 hr Exelon patches<br>Cholinesterase inhibitor patches. | 704 |

22. In relation to Patient 43 Mr 4 states that the medication prescribed is a highly specialist haematological agent for a serious blood disorder requiring specialist care throughout a patient's life. A lack of close monitoring and treatment can lead to organ damage and can even be life threatening.

23. In regard to Patient 44, Mr 4 states that Estracyt is a toxic chemotherapy medicine and should only be prescribed by a specialist. Further, Mr 4 highlights that both medications require specialist competencies as the risks involved in getting it wrong is potentially fatal.

24. In regard to Patient 45, Mr 4 states that the Cytotec may have been used as a gastro protective agent at the dose prescribed. He goes on to refer to its well-known use in the termination of pregnancies and indicates that before this was prescribed it was necessary to check that females of childbearing age are not pregnant, are using effective contraception and have been informed of the risks of taking it whilst pregnant.

25. In respect of Patients 46 – 52 Mr 4 states that these medicines should be initiated by a specialist but that thereafter, provided a prescriber has the personal competencies, a generalist prescriber could perform the long term prescribing. However, he states that up to date information about the disease is required in order to manage the dose effectively.

<u>Excessive quantities</u>

26. Mr 4 considered that a number of the prescriptions he reviewed were prescribed in excessive quantities:

| Patient number | Prescription, indication & comment | Page number of prescription |
|---|---|---|
| Patient 53 | 100 0.5mg tablets of Colchicine take as directed<br><br>Mr 4 states that this medication is used for acute gout but is toxic with prolonged use and/or overdose. The BNF states that patients should not take more than 12 tablets in three days.<br>It can be used as a prophylaxis for gout but only for short term use. | 705 |
| Patient 54 | 500 0.0625mg tablets of Lanoxin (Digoxin) one to be taken each day prescribed to a ninety two year old patient.<br><br>Mr 4 says that this drug has a narrow therapeutic index and should be reviewed at least once a year for such an old patient to avoid toxicity | 706 |
| Patient 12 | 100 2.5mg methotrexate tablets 6 tablets<br><br>Mr 4 says that the side effects of this cytotoxic immunosuppressant drug must be monitored at least every 12 weeks and that this was a 16 week course.<br><br>(This applies to each of the methotrexate prescriptions) | 664 |
| Patient 55 | 104 100 mg tablets of Sildenafil Citrate<br><br>Mr 4 says this is excessive as the UK recommended maximum is one a week. | 707 |
| Patient 56 | 12 20mg Cialis tablets & 84 5mg Tadalafil tablets. | 708 |

| | | |
|---|---|---|
| | Mr 4 describes this as an excessive quantity but also and excessive dose with the maximum licensed dose being 5mg a day. | |
| Patient 57 | 360 20mg Prozac (fluoxetine) tablets.<br><br>Mr 4 says that this is excessive given that the medication is an anti-depressant which requires patient review and potentially dose adjustment depending upon the response to medication and a patient's mental health. | 709 |

27. In respect of patients 53, 54 and 12 Mr 4 is highly critical of the prescriptions in that he states that they are potentially fatal without appropriate monitoring and dose adjustment.

28. In relation to Patients 55, 56 and 57 Mr 4 says that prescriptions of up to three months are acceptable for most medication provided the patient is already established on the medication and the appropriate information has been accessed and reviewed.

<u>Medications which are unlicensed or being used off-license</u>

29. This means that they are not licensed in the UK or are being prescribed for the treatment of a condition other than which the medication is licensed for use of in the UK.

30. Mr 4 has identified several instances in which this has taken place:

| **Patient number** | **Prescription, indication & comment** | **Page number of prescription** |
|---|---|---|
| Patient 58 | 112 90/8mg Mysimba tablets<br><br>This is a medication for the treatment of obesity but is not available in the UK for NHS prescribing. | 710 |

| | | |
|---|---|---|
| Patient 59 | 84 1mg Finasteride tablets prescribed to a female patient.<br><br>This is usually used to treat male pattern baldness and so Mr 4 considers that the gender of the patient should have been checked. | 711 |
| Patient 60 | 12 100mg Sildenafil Citrate tablets prescribed for a female.<br>Mr 4 states that this is usually used for male erectile dysfunction and is not licensed for use with females. He considers that the gender of the patient should have been checked. | 712 |
| Patient 61 | 84 5mg Finasteride tablets to be taken daily.<br><br>Mr 4 says that the usual dose when used for male pattern baldness is 1mg | 713 |
| Patient 62 | 180 4mg Glimepiride tablets to be taken twice daily.<br><br>Mr 4 says that this medication is a hypoglycaemic agent with a dose related response used widely in the treatment of diabetes and that the maximum licensed dose is 6mg a day. This has been prescribed in excess of that and Mr Williams states that it is, therefore, an off license dose and would require, at the very least, monitoring of the patient's blood sugars. | 714 |
| Patient 63 | 400 4mg Orap (pimozide) tablets.<br><br>Mr 4 describes this as a potentially cardiotoxic antipsychotic medication used for a number of unlicensed indications in particular by specialists prescribing for Tourette's syndrome. | 715 |

| | | |
|---|---|---|
| Patient 64 | 448 50mg tablets of Clomipramine tablets. 300mg to be taken daily.<br><br>Mr 4 states that this medication is a potentially cardiotoxic antipsychotic medication and that 300mg is more than the maximum licensed dose in the UK. | 716 |

31. Mr 4 considers that these examples of prescribing demonstrate a lack of attention to detail by the Registrant. Moreover, in relation to patients 63 and 64, he considers that these medications would not be expected to be prescribed by a generalist prescriber as specialist competencies are required. Further, he states that the harms associated with these medicines are potentially very serious.

Other anomalies

32. Mr 4 also identified four further instances of what he terms other anomalies. These are:

| **Patient number** | **Prescription, indication & comment** | **Page number of prescription** |
|---|---|---|
| Patient 65 | 168 40mg Nexium (Esomeprazole) tablets<br><br>Mr 4 states that a competent prescriber would want to establish the need for long-term therapy with such a high dose of a gastric acid suppressant, any history of investigation by endoscopy and to exclude any red flag symptoms of gastro intestinal malignancy. | 717 |
| Patient 66 | 90 200mg Celecoxib capsules for a seventy two year old male. | 718 |

| | | |
|---|---|---|
| | Mr 4 opines that a competent prescriber would need to establish whether the patient was also receiving gastro-protective agents due to the risk gastro-intestinal bleeding and the increased risk of cardiovascular disease caused by the medication in the over 70s. | |
| Patient 67 | 84 50/12.5mg Losartan Potassium/Hydrochlorothiazide (Cazaar comp)<br><br>Mr 4 states that in 2018 the MHRA advised prescribers of the need to discuss the risk of skin cancer in patients taking this medication long term. | 719 |
| Patient 68 | A Diaphram | 720 |

33. Mr 4 states that a competent prescriber needs to check clinical suitability of prescribed medications due to the risk of drug-drug or drug-disease interactions or contraindications. He states that Patients 65, 66 and 67 are examples of instances where prescribers would want to check, consider, discuss with patients and then record an agreed shared care plan.

34. In relation to Patient 68, Mr 4 says he would not expect a generalist prescriber to issue a prescription for a vaginal insert.

<u>Evidence of Inspector 2, in relation to her review of 38 prescriptions (Tables from the Council's Statement of Case)</u>

<u>Antimicrobials</u>

35. Patients 69 and 70 were prescribed quantities of medication which Inspector 2 considered to be in the case of Patient 69, (for 42 days)more than would routinely be supplied, and for Patient 70, (for 84 days) unusually high.

36. Patient 84 was prescribed 200 capsules of 100mg doxycycline Hyclate capsules to be taken

twice a day. Inspector 2 states that it is unusual to prescribe a hundred day supply of an antibiotic and that this is not supportive of antimicrobial stewardship.

37. Patient 71 was prescribed Metronidazole Topical Gel. Inspector 2 makes no specific criticism but states that the Registrant ought to have carried out an assessment and that the prescription demonstrates the range of medicines that were being prescribed by the Registrant.

38. Patient 72 was prescribed 250 200mg Aciclovir tablets with two tablets to be taken every 4 – 6 hours at first sign of outbreak. Inspector 2 comments that it is an unusually high quantity of the medication and that the directions to take up to every four hours is atypical and above the highest frequency advised in the BNF.

39. Patient 73 was prescribed 105 800mg tablets to be taken twice daily. Inspector 2 states that it is not routine for it to be prescribed to be taken twice daily and that the amount prescribed was unusually high.

<u>Excessive Quantities</u>

40. Patient 76 was prescribed 56 50mg tablets of Sildenafil Citrate, one to be taken a day. Mr 4 says that similar issues apply as to his comments at paragraph 85 above in relation to patients 55 and 56.

41. Patient 83 was prescribed 400 0.5mg tablets of Colchicine. Inspector 2 points out that this quantity would be enough for 33 courses at the recommended dose for acute gout and 200 days for a prophylactic course. She further highlights that an overdose of this medication could cause a haemorrhage or kidney damage.

<u>Narrow therapeutic index</u>

42. Inspector 2 refers to a number of prescriptions for Methotrexate and exhibits the relevant extract of the BNF which recommends in respect of patients being prescribed Methotrexate:

a. *"Patients to have full blood count and renal and liver function tests repeated every 12 weeks until therapy stabilised, and thereafter patients should be monitored every 2-3 months;*

b. *Patients to be advised to report all symptoms and signs suggestive of infection, especially sore throat;*

c. *Local protocols for frequency of monitoring may vary."*

43. Further, there were other prescriptions for medications with a narrow therapeutic index mentioned within Inspector 2's evidence:

| **Patient number** | **Prescription, indication & comment** | **Page number of prescription** |
|---|---|---|
| Patient 74 | 84 tablets of 100 mcg Levothyroxine Sodium<br><br>Inspector 2 states that this is used to treat low thyroid levels and that blood monitoring is required in order tailor the medication to the patient's response.<br>NICE guidance states that a patient's thyroid stimulating hormone should be monitored every three months until stabilised and annually thereafter | 726 |
| Patient 75 | 240 200mg Hydroxychloroquine Sulfate<br>Inspector 2 states that thus can be used to treat various dermatological conditions caused or aggravated by sunlight, rheumatoid arthritis or lupus.<br>She asserts that it should only be administered on expert advice and that the drug requires monitoring for retinopathy. | 727 |
| Patient 77 | 10 50mg/0.5ml Myocrisin injection | 729 |

| | | |
|---|---|---|
| | Inspector 2 states that this medication is used to treat arthritis and is administered by deep intramuscular injection. | |
| Patient 86 | 112 0.125mg Digoxin tablets<br><br>Inspector 2 sets out that this is a cardiovascular medication routinely used for atrial fibrillation or heart failure and that it has a narrow therapeutic window.<br>Electrolytes and renal function are recommended to be monitored. | 739 |
| Patient 88 | 240 1.2 g Mezavant XL (Mesalazine)<br><br>Inspector 2 states that this is used to treat ulcerative colitis and that renal function should be checked before outset, at 3 months and then annually. | 741 |
| Patient 89 | 550 500mg tablets of Mycophenolate Mofetil<br><br>Inspector 2 states that this medication is an immunosuppressant for specialist or supervised use. Further, it is known to interact with other drugs and so a prescriber should be aware if a patient is taking other medication. | 742 |

<u>Administration of injections</u>

44. In respect of the deep intramuscular injection of Myocrisin to Patient 77, Inspector 2 expresses concerns as to who would administer the injection and whether they were appropriately trained to do so.

45. Patient 79 was prescribed 2 40mcg Viridial 40 Duo Starter Pack injections for erectile dysfunction. Inspector 2 states that the injection can be administered safely at home but that counselling as to how to administer the injection is required.

Specialist Conditions

46. Inspector 2 also comments on some prescriptions for medications for specialist conditions:

| **Patient number** | **Prescription, indication & comment** | **Page number of prescription** |
|---|---|---|
| Patient 78 | 112 5mg Aripiprazole tablets<br><br>Inspector 2 states that this is used to treat schizophrenia and is usually initiated by a specialist. | 730 |
| Patient 80 | 60 25mg capsules of Acitiretin.<br><br>Inspector 2 describes this as a retinoid used to treat skin conditions which should only be prescribed under expert supervision and notes that the BNF states that monitoring is required in some instances as regularly as every two to four weeks.<br>Inspector 2 also mentions the potential for neuropsychiatric reactions in patients taking oral retinoids and that monitoring and counselling in this regard is necessary.<br>Further, Inspector 2 says that patients should be counselled on avoiding exposure to sunlight and not to donate blood. | 733 |
| Patient 82 | 200 140mg Estracyt (Estramustine) capsules | 735 |

| | | |
|---|---|---|
| | Inspector 2 states that this is a cytotoxic drug which is used to treat prostate cancer. | |
| Patient 87 | 120 50mg tablets of Solian (Amisulpride).<br><br>Inspector 2 states that this is an anti-psychotic used to treat schizophrenia. | 740 |

Other

47. Patient 81 was prescribed 84 80mg Edarbi tablets. Mr 4 says in his report that although uncommon in the UK this is a widely used class of blood pressure medication with no special requirements other than a blood pressure reading and an annual renal function test.

48. Patient 85 was prescribed 112 40mg Esomeprazole capsules. Inspector 2 states that this a proton pump inhibitor routinely used to treat acid reflux, stomach ulcers and stomach infections. She states that the quantity prescribed amounts to a 16 week course and she states that if symptoms did not relieve in a shorter time the patient may have required a referral for investigation into the root of the problem.

49. Patient 90 was prescribed 180 500mg Ranexa tablets. Inspector 2 gives evidence that this medication is used to treat angina but that there are several cautions advised with this drug including, if the patient is under 60 kg, has moderate to severe heart failure or renal impairment.

**Oral Evidence of the Registrant**

50. The Registrant gave evidence on oath and was cross examined by Mr Corrie at some length.

51. In relation to particulars 1 and 2, the Registrant explained that he thought he was allowed to prescribe medication for animals, but he admitted that he had not done sufficient

research into the relevant guidelines to be sure. He readily admitted that in fact what he had done in prescribing the medications listed in Schedule A was not within his scope of practice as he was not a vet. In relation to particular 3, he admitted that his conduct in relying for the most part on the clinical assessments of foreign prescribing physicians was inadequate, and he was forthright in admitting that he knew at the time that as an independent prescriber he was professionally responsible for the prescriptions which he issued. His explanation, in terms similar to his Witness Statement, was that since the overseas prescribing physicians were stated to be specialists in their fields, and since under the terms of the Medimart agreements, it was Medimart which took responsibility for checking the appropriateness of the prescriptions and that appropriate clinical checks and monitoring had been carried out, he thought at the time that it was safe to act as he did.

52. He stated at first that he worked for an average of four hours per evening for Medimart. He would access their portal and then each patient prescription containing dose and formulation, alongside one page of additional information about the patient, which gave some "limited patient medical history", and information about allergies, age, size, gender. He would then review the prescription against Medimart's transcriber prescription. He would take about 5 minutes on "normal" prescriptions, longer on more complex ones. However, under cross examination he conceded that he could not have taken as long as he said reviewing each prescription and must often have worked for more than four hours, given the quantity of prescriptions he was signing off every day during June – July 2019.

53. He would refer to the British National Formulary ("BNF") and the Electronic Medical Compendium as necessary, and raise queries by phone with Medimart or by "telegram", an online messaging system, but he felt that Medimart did not like him raising too many queries, (they would fail to respond to him). He admitted that, as time went on, this affected his diligence in doing so. However, he drew the Committee's attention to the audit within the Council's bundle of approximately 4,500 prescriptions which he had rejected, as evidence that he had taken some responsibility overall.

54. The Registrant admitted that as sole breadwinner for his family he was working at a number of jobs simultaneously, but he stated that his chief motivation in taking on the

role with Medimart was to ensure continuation of medication and cost effectiveness for the patients.

55. He said that at first the system had seemed adequate but as the process continued, the number of prescriptions he was expected to issue rose steeply. He said he raised concerns with the dispensing pharmacist, though he could not recall exactly when he did so, however he had continued with the arrangement despite his concerns.

56. In cross examination the Registrant admitted that he had no specific competence or expertise in many of the health conditions for which he issued prescriptions for Medimart, and he apologised to the Committee for so doing. He readily accepted that his conduct fell short of the standards expected of a pharmacist working in an independent prescribing role. He stated that the risks associated with not having adequate information to prescribe safely, would include adverse effects, both in relation to the efficacy of medication and also adverse side effects, and could lead to harm to patients and co-morbidities. The harm could have been "very serious". He was "ashamed". He appreciated that his conduct had brought his profession into disrepute.

57. He told the Committee about the training he had undergone since the relevant events and about his current work, which was in the main locum work in a multidisciplinary setting which he enjoyed. Due to interim conditions, he had not practised as a PIP since August 2019, but he said he had reflected on his practice and was confident that in future he would only practice within his scope of competence and would refer to specialists or refuse to prescribe if he ever found himself in circumstances similar to those which existed at the time of the events in question.

**Submissions on behalf of the Council**

58. Mr Corrie, on behalf of the Council, referred the Committee to the Council's Skeleton Argument and to the case law cited therein, namely the cases of *Cheatle v GMC* [2009] EWHC 645 (Admin); *Roylance v GMC* [No 2] [2000] 1 AC 311; *Cohen v GMC* [2008] EWHC 581 (Admin); *Zygmunt v GMC* [2008] EWHC 2643 (Admin); *CHRE v Grant* [2011] EWHC 927 (Admin) , and *Yeong v GMC* [2009] EWHC 1923 (Admin). He also referred the Committee to the Council's Good Decision Making Guidance (2017).

59. In relation to the ground of misconduct, Mr Corrie submitted that the Registrant had breached standards 1, 2, 3, 5, 6 and 9 of the GPhC's Standards for Pharmacy Professionals (2017), and had failed to act in accordance with the principles set out within the Royal Pharmaceutical Society Competency Framework and the GPhC Standards for Education and Training. He submitted that the Registrant's conduct was "particularly serious misconduct". He submitted that given the quantity of prescriptions the Registrant issued during June-July 2019, his clinical checks must have been "cursory, and transactional", and that his actions were a serious departure from what was required and expected in the following respects:

i. Failing to take responsibility and be accountable for his prescribing practice;
ii. Being involved in a high volume online prescribing operation without giving adequate considerations to the safety of the system within which he was operating
iii. A gross and repeated disregard for patient safety;
iv. Acting outside the scope of your practice;
v. Allowing perceived pressure from Medimart in relation to deadlines to compromise the quality of patient care;
vi. Causing an unwarranted risk of serious harm to multiple patients.

60. On the issue of whether the Registrant's fitness to practise is currently impaired, Mr Corrie referred the Committee to Rule 5(2) which he said enshrines the tests identified by Dame Janet Smith in the Fifth Shipman Inquiry Report. He submitted that the Registrant's insight was not fully developed, and that given the Registrant had not practised as a PIP since the events in question, he had no independent evidence to show remediation, and therefore there remained a risk of repetition. In relation to the wider public interest, Mr Corrie submitted that online prescribing is a particular cause for concern in pharmaceutical practice and the public would expect the Regulator to treat misconduct in this area particularly seriously. It was therefore necessary to mark the Registrant's misconduct with a finding of current impairment whether or not the Committee were to consider that there remains a risk of repetition in relation to the Registrant's standard of practice. He submitted that on the facts of the case, Rules 5(2) (a), (b) and (c ) were engaged.

**Submissions on behalf of the Registrant**

61. Mr McCartney on behalf of the Registrant began by accepting that the conduct found proved was serious enough to amount to misconduct. He submitted that the Registrant's unequivocal admissions of all of the alleged facts demonstrated his insight into his misconduct. He drew the Committee's attention to the well-known case of ***Cheatle***, also referred to by Mr Corrie, and the principle it contained to the effect that a Registrant's fitness to practise should be assessed in relation to likelihood of future misconduct.

62. He reminded the Committee that the Registrant, though responsible for his own prescribing, was just one part of an arrangement which also included other parties, including Medimart and also the dispensing pharmacist. The Registrant had relied on Medimart's contractual assurances that they would be responsible for checking that the prescribing physicians had correctly undertaken all necessary clinical checks and monitoring, and it was on that basis that the Registrant had understood himself to be "co-signing" the prescriptions. The Registrant's admitted failure therefore was in relation to his over- reliance on the assessments made by the treating prescribers, and his failure to recognise the limits of his own prescribing arising from the process, which, Mr McCartney admitted, on behalf of the Registrant, was flawed. Although the Registrant knew the relevant pharmacy rules and guidance, he had not understood how they applied to this particular arrangement.

63. Mr McCartney reminded the Committee that Mr 4 had only found 5% of the prescriptions he had examined to fall below an acceptable standard and there was no evidence of actual harm to patients, though he accepted that his conduct would have created a risk of harm.

64. Mr McCartney drew the Committee's attention to the Registrant's reflections in his Witness Statement and to the positive testimonials contained within the Registrant's bundle, and to the training the Registrant had undergone, however he accepted on the Registrant's behalf that due to the interim conditions, the Committee may feel that the Registrant had not been able to demonstrate full remediation in relation to his independent prescribing skills. He also accepted on the Registrant's behalf that the wider public interest considerations were engaged by the facts of the case.

**The Committee's Determination**

65. The Committee took into account all of the evidence before it at this stage of the hearing, and also took account of the relevant law and the submissions made by Mr Corrie on behalf of the Council, and by Mr McCartney behalf of the Registrant.

66. The Committee noted the principles derived from relevant case law, which, in summary, require the Committee to engage in a "two-stage process"; first to consider whether, in this case, misconduct is established, and if so, then to go on to consider whether as a result of that misconduct, the Registrant's fitness to practise is currently impaired. The Committee must take into account that the purpose of these proceedings is not to punish the Registrant for past deeds but to protect the public from current or future risk. In assessing such risk, the Committee must look forwards, not backwards, but it may need to consider the Registrant's past conduct to do so. The Committee must take account of any insight, remorse or remediation the Registrant has demonstrated. A Registrant's fitness to practise must be assessed by reference not only to their standards of practice, but also to whether their past acts have brought their professional standing or the profession of pharmacy into disrepute, or undermined confidence in their profession, such that a finding of current impairment is required on public interest grounds.

67. The Committee bore in mind the Good Decision making: Fitness to practise hearings and sanctions guidance (March 2017), and noted in particular the following paragraphs:

*"2.11 A pharmacy professional is "fit to practise" when they have the skills, knowledge character, behaviour and health needed to work as a pharmacist or pharmacy technician safely and effectively. In practical terms, this means maintaining appropriate standards of competence, demonstrating good character, and adhering to the principles of good practice set out in our various standards, guidance and advice.*
*2.13 The committee …must decide whether the registrant's fitness to practise is currently impaired, not whether it was at the time the incident occurred."*

68. "Misconduct" is one of the reasons, or grounds, which can open the "gateway" for a finding of impairment, as provided for by Article 51(1)(a) of the Pharmacy Order 2010 ("the Order").

69. Rule 5(1) of the Rules states that the Committee must have regard to the criteria specified in paragraph 5(2) when deciding if the requirements as to fitness to practise are met in relation to a registrant.

70. Rule 5(2) provides:

*(2) In relation to evidence about the conduct or behaviour of the registrant which might cast doubt on whether the requirements as to fitness to practise are met in relation to the registrant, the Committee must have regard to whether or not that conduct or behaviour –*

*(a) presents an actual or potential risk to patients or to the public;*

*(b) has brought, or might bring, the profession of pharmacy into disrepute;*

*(c) has breached one of the fundamental principles of the profession of pharmacy; or*

*(d) shows that the integrity of the Registrant can no longer be relied on.*

71. In relation to the allegation of misconduct, the Council's case was that the Registrant, although purporting to be operating as an independent prescriber, for which he had been qualified since 2012, was at fault for having delegated his responsibility to Medimart and the overseas prescribers. The Committee accepted the evidence of Mr Williams who set out the various rules and guidance which expressed the responsibilities of an independent prescriber.

72. The Royal Pharmaceutical Society Competency Framework ("the Framework") defines independent prescribing as '*prescribing by a practitioner, who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing'.*

73. Having assessed the nature of the agreement between the Registrant and Medimart, Mr 4 concluded that "*the Registrant was operating as an independent prescriber and having completed the necessary prescribing qualification they would have been clear as to their responsibilities around clinical assessment, appropriate monitoring, and adjustment*

*thereof for any medication prescribed".*

74. The GPhC Standards for the education and training of pharmacist independent prescribers ("the Education Standards") define the prescribing role thus:

*"the prescriber takes responsibility for the clinical assessment of the patient, establishing a diagnosis, and the clinical management required as well as the responsibility for prescribing and the appropriateness of any prescribing" (National Prescribing Centre, 2005)*; and the Framework makes it clear that '*pharmacist prescribers should assess, consider options, reached a shared decision, prescribe, provide information, monitor and review when prescribing for patients*'.

Mr 4 also stated in his expert report that the Framework states that a prescriber:

- *must only work within their scope of practice recognising the limits of their own knowledge and skill;*
- *accepts personal responsibility for prescribing and understands the legal and ethical implications;*
- *knows and works within legal and regulatory frameworks affecting prescribing practice (e.g. controlled drugs, prescribing of unlicensed/off label medicines, regulators guidance, supplementary prescribing).*

75. The Committee accepted the submissions of Mr Corrie in relation to the Council's Standards for pharmacy professionals (May 2017), and accordingly it was of the view that the Registrant had breached the following standards:
*1 provide person-centred care*
*2 work in partnership with others*
*3 communicate effectively*
*5 use professional judgement*
*6 behave in a professional manner*
*9 demonstrate leadership*

76. There were numerous failings and omissions in the Registrant's prescribing practice. By his own admission, his breaches in several professional standards were "very serious" and

put patients at risk of serious harm. The Registrant told the Committee that he had, at some point, spoken to the dispensing pharmacist regarding his concerns about the process. However, he failed to follow up on this with the result that more patients were put at risk of harm. The Committee therefore considered that the Registrant had breached Standard 8, which requires a pharmacist to *"speak up when they have concerns or when things go wrong"*.

77. The Committee carefully considered all of the evidence provided by the witnesses. It took into account the concerns of Inspector 1 in her inspection report of the registered pharmacy on 15 May 2019, which highlighted that most standards of governance were not met. Furthermore, she noted flaws in relation to the premises and services provided by the pharmacy. The Committee also carefully considered the detailed reviews of prescriptions provided by Inspector 2 and Mr 4. It was content to accept both the analysis of Inspector 2 and the analysis and expert opinion of Mr 4 in relation to the potential dangers of the prescriptions they reviewed. The Committee was particularly concerned to see the overall conclusions of Mr 4 regarding the Registrant's standard of care, which is set out below:

*"It is therefore my opinion, based on the evidence I have seen, that the registrant prescribed indiscriminately, irrationally, and unsafely without the necessary clinical assessment/ checks and suitable monitoring expected within the RPS competency framework, and thus far below their scope of practice and competency as a pharmacist independent prescriber…*

*I would further contend that no prescriber, medical or otherwise, could fulfil all the specialist competencies required to safely and effectively prescribe the breadth and variety of medicines prescribed by the registrant .From the selection of the thousands of prescriptions provided to me to review, my clinical opinions above show that the registrant would need to have had vast in-depth specialist knowledge and skills covering the pathophysiology of the all the major body organ systems and the pharmacodynamics , pharmacokinetics and monitoring requirements for virtually all the classes of medicines within the British National Formulary."*

78. The Committee took into account that Mr 4 was concerned only in relation to 5% of the prescriptions he reviewed but considered this in the context of the high number of prescriptions issued by the Registrant overall and the very serious risks of harm which such prescribing could have entailed. It also appreciated that the Registrant was one part of a prescribing process which was itself flawed and unsafe, and that others may also bear some responsibility. However, the Registrant himself had a duty of care towards the patients for whom he issued prescriptions to ensure that he carried out his responsibilities to the required professional standard. The Committee considered the Registrant's responsibility for prescribing medications in high volumes, without carrying out adequate clinical and/or monitoring checks and outside the scope of his competence, and at a pace set by the purchaser of his services (Medimart) which took no account of the time it should take him to practise safely, in the light of the principle set out by Lord Clyde in *Roylance and General Medical Council* (No.2) [2000] 1 A.C. 311, to determine whether the Registrant's conduct *"[fell] short of what would be proper in the circumstances".* It concluded that the evidence suggested an alarming and serious departure from what was required in the circumstances, which was sufficiently serious to amount to misconduct. In addition, in relation to the medications set out in Schedule A, the Committee considered that he had breached his professional responsibility to ensure before doing so that he was properly authorised. It considered that his omission to check the relevant rules and guidelines before prescribing human and POM-V medications for animals fell far below the standard which was expected of him.

79. The Committee next turned to consider whether, by reason of his misconduct, the Registrant's fitness to practise is currently impaired. It applied the well known guidance of Mr Justice Silber in *Cohen v General Medical Council [2008] EWHC 581 (Admin)* at paragraph 65: "*It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated"*. The Committee was aware that these principles are echoed in the Council's Guidance at Paragraph 2.14. It also took into account the principles set out in *Yeong v General Medical Council* [2009] EWHC 1923 (Admin) in which Mr Justice Sales said at paragraph 21:

*"It is a corollary of the test to be applied and of the principle that a FTPP is required to look forward rather than backward that a finding of misconduct in the past does not necessarily*

*mean that there is impairment of fitness to practise – a point emphasised in Cohen and Zygmunt…In looking forward, the FTPP is required to take account of such matters as the insight of the practitioner into the source of his misconduct, and any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required to have regard to evidence about these mattes which has arisen since the alleged misconduct occurred."*

80. Pharmacists are gatekeepers of medicines. The deficiencies in the Registrant's practice were serious, fundamental, and wide-ranging, affecting potentially hundreds of patients.

81. In relation to the Registrant's insight into his failings, the Committee gave him credit for his unequivocal admissions of all the facts alleged, for commencing refresher Return to Prescribing training soon after the investigation began, and also for his appreciation, as submitted on his behalf by Mr McCartney, that the Committee might well conclude that his conduct amounted to misconduct and impairment.

82. The Committee considered the Registrant's reflections in his Witness Statement and concluded that although they go some way to demonstrating that he understands his failings in broad terms, they are not sufficient to address the issues raised by the facts found proved. The Committee would have expected to see evidence of the Registrant's detailed reflections on the risks of prescribing at a distance and how to safeguard against those risks. Relevant guidance from the Council includes the "Guidance for Registered Pharmacies At a Distance" (April 2019), paragraph 4 of which states that prescribers should *"have adequate knowledge of the person's health and [be] satisfied that the drugs serve the person's needs";* and the Council's "In Practice Guidance for Pharmacist Prescribers", which gives safeguarding guidance for when on-line prescribing.

83. The Registrant did not provide any detailed assessment, reflection, or insight into the prescriptions he had in fact issued, and how and why they were inadequate, in so many ways, as was very clearly described by the witnesses. The Committee considered that in order for it to be sure that the Registrant had fully taken on board the specificities of his failures in relation to the prescriptions listed in Schedules A and B, it would have been useful for the Registrant to have produced a reflective document demonstrating clearly

his learnings in relation to those prescriptions and the medications he had "co-signed" for, and the risks associated with his practice at the time.

84. In relation to remediation, the Committee took into account the seven positive testimonials from colleagues including former and current line managers, and the significant amount of relevant CPD he had undertaken, with highly reputable training institutions. The Committee did not accept Mr Corrie's submission that the fact that the training took place nearly two years ago had any bearing on its continuing utility; however, it did consider that his observations in relation to the fact that the Registrant has not in fact worked as a PIP since the relevant events, does have relevance to an assessment of current or future risk. Applying the considerations set out in ***Cohen***, the Committee concluded that whilst the Registrant's conduct is, in principle remediable, it has not been fully remedied, and the Committee cannot today conclude that it is highly unlikely to be repeated.

85. In the light of these observations, the Committee turned to consider whether any sub-particulars of Rule 5(2) of the Rules are engaged by the Registrant's misconduct. The Committee considered that, given the lack of demonstration of full insight into the actual prescriptions listed in the schedules, and why they were inadequate, and the lack of objective and independent evidence that the Registrant can now be trusted to prescribe safely and effectively, Rule 5(2)(a) is engaged, in that the Registrant currently *"presents an actual or potential risk to patients or to the public"*. The Committee was also of the view that the Registrant's misconduct clearly has brought the profession of pharmacy into disrepute (Rule 5(2)(b)), and that in breaching the standards for professionals as set out above, he breached one or more fundamental principles of the profession (Rule 5(2)(c ). The Committee did not consider that the Registrant's integrity was called into question by the facts of this case and therefore it did not consider that Rule 5 (2) (d) was engaged.

86. In relation to the public interest, the Committee bore in mind the well-known words of Mrs Justice Cox in the case of ***Grant***, in which she stated that a panel must consider whether *"the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances"* of a case. The Committee accepted the submissions of Mr

Corrie in relation to the importance to the public of upholding professional standards when providing pharmacy services at a distance. The Committee was aware that this is an area of pharmacy practice which is becoming more common, and that it carries particular risks which need to be managed. The nature of the Registrant's misconduct, extending as it did over a very large number of instances of unsafe prescribing in specialist areas such as mental health, cancer, paediatric epilepsy, and HIV, and issuing prescriptions for medications with a narrow therapeutic index and for unusual amounts and in excessive quantities ought to be marked by a finding of impairment in the public interest. This would send a clear message to professionals and the public that misconduct of this sort when prescribing at a distance will not be tolerated by the Regulator. The Committee was in no doubt that the public's trust in the pharmacy profession would be irrevocably undermined if a finding of impairment were not made, in order to uphold confidence in the profession to maintain appropriate standards of practice, and also to maintain confidence in the Council as a regulator.

87. For all the reasons set out above, the Committee concludes that the Registrant's current fitness to practise is impaired, by reason of his misconduct, on both the personal and the public components, that is, both for the protection of the public, and in the wider public interest.

**THE SANCTION STAGE**

1. Having found that the Registrant's fitness to practise is currently impaired, the Committee turned to consider the question of what, if any, sanction it should impose.

2. The Committee's powers in relation to sanction are set out Article 54(2) of the Pharmacy Order 2010 as follows:

*"(2) If the Fitness to Practise Committee determines that the fitness to practise of the person concerned is impaired, it may—*

*(a) give a warning to the person concerned in connection with any matter arising out of, or related to, the allegation and give a direction that details of the warning be recorded in the Register;*

*(b) give advice to any other person or other body involved in the investigation of the allegation on any issue arising out of, or related to, the allegation;*
*(c) give a direction that the entry in the Register of the person concerned be removed;*
*(d) give a direction that the entry in the Register of the person concerned be suspended, for such period not exceeding 12 months as may be specified in the direction; or*
*(e) give a direction that the entry in the Register of the person concerned be conditional upon that person complying, during such period not exceeding 3 years as may be specified in the direction, with such requirements specified in the direction as the Committee thinks fit to impose for the protection of the public or otherwise in the public interest or in the interests of the person concerned."*

3. In addition, the Committee should have regard to the Council's "Good decision making: Fitness to Practice Hearings and Sanctions Guidance" (2017) ("the Sanctions Guidance").

**Submissions on behalf of the Council**

4. Mr Corrie summarised the law and drew the Committee's attention to the Council's Sanctions Guidance. He submitted that the Registrant's misconduct should be regarded as very serious because there was a particular public interest in ensuring that on-line pharmacy services are safe and effective, due to the inherent risks involved, and he set out on the Council's behalf, a list of mitigating and aggravating features which he submitted the Committee should take into account when considering sanction.

5. He submitted that although it might be possible to formulate conditions of practice which could protect the public in this case and there were good grounds to expect that the Registrant would comply with conditions, since he had complied with interim conditions, nevertheless in view of the seriousness of his misconduct, the appropriate and proportionate sanction in this case was one of suspension for a period of 12 months.

**Submissions on behalf of the Registrant**

6. Mr McCartney on behalf of the Registrant submitted that the real flaw in the Registrant's practice had been an over-reliance on the treating physicians without adequate information, rather than prescribing outside his scope of competence with no safety net whatsoever, and there was no evidence of actual patient harm. He submitted that the Committee ought not to approach the facts of this case as being in a special category warranting a particularly grave sanction based on the misconduct having occurred in an on-line context.

7. He submitted that the correct approach at sanction stage was for the Committee to impose the least necessary sanction which would meet the regulatory objectives, and that the Committee's finding of current impairment was itself sufficient as a message in the public interest of the seriousness with which the Regulator takes the Registrant's misconduct. Referring to the relevant part of the Sanctions Guidance, Mr McCartney submitted that the appropriate and fair sanction was one of conditions. He said the Registrant had shown himself able to work safely under interim conditions and moreover Mr Corrie himself had accepted that conditions would be adequate to protect the public. Mr McCartney submitted that the Registrant was ready and willing to comply with any conditions the Committee might wish to impose, and he suggested direct supervision by a mentor, supervisor's reports and appropriate and documented reflection might be a satisfactory approach for the Committee to take in relation to sanction.

**The Committee's decision on sanction**

8. The Committee applied the relevant law and took into account the Council's "Sanctions Guidance". It took into account the submissions of Mr Corrie on behalf of the Council, and Mr McCartney on behalf of the Registrant. It took into account relevant documentation including the Registrant's Witness Statement and the positive testimonials he had provided for the purposes of the hearing.

9. The Committee was mindful that the purpose of sanction in regulatory proceedings is not to punish registrants, but to protect patients and the wider public interest. However, the effect of some sanctions may be punitive. The Committee should balance the public interest against the Registrant's own interests and should apply the principle of

proportionality. However, in accordance with the words of Lord Bingham in the case of the *Bolton v The Law Society [1994] 2 All 486,* confirmed as good law in the case of *Law Society v Brendan John Salsbury* [2008] EWCA Civ 1285, the Committee is entitled to give greater weight to the public interest and the need to maintain public confidence in the profession than to the consequences for the Registrant of imposing any particular sanction.

10. The Committee considered that the mitigating features in this case include:

(a) No evidence of patient harm;
(b) The Registrant made full admissions, has meaningfully engaged with these proceedings, expressed remorse and has shown some insight into his failings;
(c) A number of positive testimonials;
(d) The Registrant has an unblemished previous record with the Council.

11. The aggravating features include:

(a) Several breaches of a number of the Standards for Pharmacists over a significant 12 month period;
(b) Involvement in high volume prescribing for large numbers of patients with gross and repeated disregard for their safety;
(c) Having raised concerns with the dispensing pharmacist, therefore having realised that the process was unsatisfactory, he nevertheless continued to prescribe medication in accordance with the agreement;
(d) He knowingly acted outside the scope of his practice in multiple areas of prescribing;
(e) The Registrant's misconduct could have continued of it had not been picked up as a result of the Council's inspection.

12. The Committee first considered whether it should take no action or impose a warning. The Committee concluded that neither of these outcomes would be appropriate as they would provide no means of protecting the public, nor of restoring and maintaining confidence in the profession and the regulatory process. Both would be insufficient to reflect the seriousness of the misconduct.

13. In view of the submissions made on behalf of both parties, the Committee gave careful consideration to whether it would be proportionate and appropriate to impose an order of conditional entry on the Registrant's registration at this stage. The Council's Sanctions Guidance states at page 21 that conditions may apply where,

"*there is evidence of poor performance, or significant shortcomings in a Registrant's practice, but the committee is satisfied that the registrant may respond positively to retraining and supervision. There is not a significant risk posed to the public, and it is safe for the registrant to return to practice but with restrictions".*

14. The Committee acknowledged that the Registrant had shown himself not only willing to comply with conditions during the interim period but also able to practise safely as a pharmacist over nearly three years since the relevant events. Mr McCartney had confirmed in submissions that the Registrant would be willing to comply with any supervision or other conditions which the Committee might impose. The Committee took full account of the positive testimonials which the Registrant had provided. However, it also bore in mind that due to the interim conditions imposed on his practice, and although he had undertaken significant and relevant training, the Registrant had not in fact practised as an independent prescriber over those three years. The Committee had already made observations in relation to the Registrant's incomplete insight in that he had not provided detailed reflections into the specific**,** and broad-ranging failings he had made in prescribing, nor, in the Committee's view, had he made any more than relatively cursory or general reference to the particular dangers inherent in on-line prescribing.

15. Whilst the Committee considered it would be possible to impose conditions on the Registrant's practice along the lines suggested by Mr McCartney, which would guard against risk of repetition, the Committee was of the view, given all of the circumstances of this case, that an order of conditional entry at this stage would not send a sufficiently clear message to the public nor to the profession which would demonstrate the seriousness of the Registrant's misconduct.

16. The Committee next turned to consider whether a suspension would be a proportionate sanction.

17. It took into account Page 22 of the Sanctions Guidance which states, in relation to suspension,

*"It may be required when necessary to highlight to the profession and the public that the conduct of the registrant is unacceptable and unbefitting a member of the pharmacy profession. Also when public confidence in the profession demands no lesser sanction".*

18. The Committee has already observed that the Registrant's misconduct was, in its view, particularly serious, both in view of the multiple numbers of prescriptions he issued, in multiple areas of practice outside his scope of expertise, and also, the admitted lack of diligence with which he checked them for clinical appropriateness and proper monitoring. It is important that the Registrant's misconduct including his failures and omissions are seen in the context of his practice at the time as a PIP for an on-line pharmacy. The Committee does consider that the public interest considerations raised by the facts of this case are particularly acute because prescribing at a distance carries particular risks which the Registrant failed to take into account when agreeing to the process with Medimart and when operating as part of that process.

19. It therefore considers that no less a sanction than a period of suspension from the Register will suffice to send an appropriate and clear message to professionals and to the public of the seriousness with which the Regulator takes these matters. This will ensure that the public can continue to have confidence in the profession, particularly as the provision of on-line pharmacy services continues to become more popular, along with upholding professional standards and maintaining the public's confidence in the Regulator itself.

20. Having concluded that an order of suspension was likely to be sufficient and proportionate in all the circumstances of the case, the Committee briefly turned to consider whether this was a case in which the most serious sanction, that of removal, was appropriate. The Sanctions Guidance states that removal is *"reserved for the most serious conduct"* and that it should be considered *"when the registrant's behaviour is fundamentally incompatible with being a registered professional".* The Committee concluded that removal would be disproportionate given the facts of this case and the Committee's conclusion at the impairment stage that the misconduct found proved was remediable.

21. The Committee therefore resolved to give a direction that the Registrant's entry in the Register be suspended. It considered Mr Corrie's submission on the Council's behalf that no less than 12 months was a proportionate length for a suspension, but it determined that a shorter period of four months' suspension would be sufficient in all the circumstances. In coming to this conclusion, the Committee took into account that the Registrant has worked as a pharmacist (albeit not as a PIP) for close to three years since the relevant events, without further regulatory issues being raised in relation to his practice and has provided signed and dated testimonials from professional colleagues who are aware of the allegations against him but nevertheless consider his practice to be of a high standard. It also took into account that it would have been possible to impose conditions on his practice which could have guarded against the risk of repetition.

22. This short period of suspension will also enable the Registrant to develop his insight further and fully into his failings, and to demonstrate that he fully appreciates the particular risks which were raised by the agreement he entered into with Medimart and the effect of that agreement upon his professional duties and responsibilities as an independent prescriber.

23. The Committee considers that this is a case in which a review ought to be held before the expiry of the period of suspension, so that a reviewing committee can make a decision as to whether it considers that the Registrant is safe at that time to practice with or without further restriction.

24. This Committee considers that the reviewing committee would be assisted by the Registrant providing the following:

i) A reflective document demonstrating the Registrant's full insight into the specifics of the failings in relation to the prescriptions he issued in his on-line prescribing practice with Medimart. The document should clearly set out his further learnings in relation to the specific risks associated with prescribing at a distance. The Registrant may wish to consider and make reference to the following Guidance:
"Guidance for Registered Pharmacies At a Distance" (April 2019), paragraph 4 of which states that prescribers should *"have adequate knowledge of the person's health and [be] satisfied that the drugs serve the person's needs";* and the Council's "In Practice Guidance for Pharmacist Prescribers" (November 2019), which gives safeguarding guidance for when on-line prescribing;

ii) Any other documentation the Registrant considers will be helpful at that stage, for example testimonials in relation to paid or unpaid work; or evidence of further learning in relation to the risks of on-line prescribing, if he undertakes any;

iii) Evidence of CPD or other study undertaken during the period of suspension;

iv) Identification by the Registrant of his particular areas of competency as a PIP, to include the basis for such competency in those particular areas for example training, audits and supervision records.

25. The Committee hereby revokes the interim order of conditions which was in place in respect of the Registrant, pursuant to Article 56(10) of the Pharmacy Order 2010.

ORDER: The Committee directs the Registrar to suspend the name of Mr MUAMAR IQBAL (Registration number 2059871) from the Register for a period of four months.

**DECISION ON INTERIM MEASURE**

1. Mr Corrie, for the Council, made an application for an interim measure of suspension to be imposed on the Registrant's registration, pursuant to Article 60 of the Pharmacy Order 2010, pending the coming into force of the Committee's substantive order. He submitted that such an order was necessary to protect the public and was otherwise in the public interest.

2. Mr McCartney, on the Registrant's behalf opposed the application. He submitted that, as the Registrant's representative, he could give an assurance on the Registrant's behalf that the Registrant would not undertake any work as a PIP during the 28 day period of appeal. He submitted that the Committee could rely on such an assurance given that the Registrant had complied with the interim conditions. There would be a review prior to expiry of the suspension period in which a reviewing committee would be informed as to whether he had indeed complied with such an assurance, and if he did not then a question would be raised as to his integrity, which is not in issue in this case.

3. Mr Corrie reminded the Committee that an assurance was just that: it would be unenforceable and therefore, given the need for public protection which the Committee had identified at the impairment stage, it was necessary to impose interim measures. The only available interim measure in this case, given the substantive order of suspension, was an interim measure of suspension.

4. The Committee carefully considered the submissions on behalf of both parties. It took account of the fact that its decision to order the suspension of the Registrant's name from the register will not take effect until 28 days after the Registrant is formally notified of the outcome, or until any appeal is concluded.

5. The Committee has found that the Registrant's misconduct merits an order of

suspension, not only because there remains a risk that the Registrant might repeat his conduct, and this could pose a risk of harm to the public, but also given the public interest issues which the Committee has found to be engaged by the facts of this case. It is satisfied that it is therefore necessary for there to be some measure of public protection in place prior to the taking effect of the substantive order.

6. The Committee therefore hereby orders that the entry of the Registrant in the register be suspended forthwith, pending the coming into force of the substantive order.